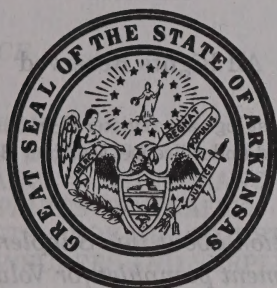


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Under the Direction and Supervision of the
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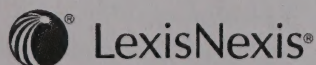
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TITLE 23

PUBLIC UTILITIES AND REGULATED INDUSTRIES

(CHAPTERS 1-29 IN VOLUME 22; CHAPTERS 30-59 IN VOLUME 23A; CHAPTERS 74-87 IN VOLUME 24A; CHAPTERS 88-117 IN VOLUME 24B)

SUBTITLE 3. INSURANCE

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SUBTITLE 3. INSURANCE

CHAPTER 60

GENERAL PROVISIONS

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SECTION.

- 23-60-108. Penalty generally.
- 23-60-112. American Law Institute — Restatement not public policy.

23-60-103. Application of code.

Unless otherwise expressly provided for in the Arkansas Insurance Code, no provision of the Arkansas Insurance Code shall apply with respect to the following entities:

- (1) Domestic stipulated premium insurers, as identified in § 23-71-101 et seq., concerning stipulated premium insurers except as stated in those sections;

(2) Assessment life, health, and accident insurers, as identified in § 23-72-102 et seq., concerning assessment life and disability insurers except as stated in those sections;

(3) Farmers' mutual aid associations or companies, as identified in § 23-73-102 et seq., concerning farmers' mutual aid associations or companies except as stated in those sections, but excepting the requirements for fraudulent insurance acts prevention, codified in § 23-66-501 et seq., and including the payment of assessments due from insurers and other licensees under the State Insurance Department Criminal Investigation Division Trust Fund Act, § 23-100-101 et seq., which shall apply to farmers' mutual aid associations or companies;

(4) Fraternal benefit societies, as identified in § 23-74-101 et seq., concerning fraternal benefit societies except as stated in those sections; and

(5) Nonprofit vision service plan corporations composed of at least fifty (50) participating optometrists or ophthalmologists licensed by the State of Arkansas to provide vision care services on a prepaid basis when each licensed optometrist or ophthalmologist is subject to the rules of the professional's respective state board and when each participating licensed optometrist or ophthalmologist agrees to assume responsibility for completion of the provisions of the vision care services contracted for so that no element of risk is incurred by any subscriber group or person.

History. Acts 1959, No. 148, § 11; 1983, No. 624, § 1; A.S.A. 1947, § 66-2011; Acts 2001, No. 1604, § 1; 2019, No. 315, § 2608.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (5).

23-60-104. Exceptions — Burial associations — Healthcare sharing ministries — Direct healthcare agreements — Definitions.

(a) The Arkansas Insurance Code and rules promulgated by the Insurance Commissioner under the Arkansas Insurance Code do not apply to a:

(1) Burial association governed by §§ 23-78-101 — 23-78-119 and 23-78-121 — 23-78-125;

(2) Direct healthcare agreement; or

(3) Healthcare sharing ministry.

(b) As used in this section:

(1)(A) "Direct healthcare agreement" means a written agreement that:

(i) Is between a licensed healthcare provider and a patient or the patient's legal representative;

(ii)(a) Allows either party to terminate the agreement in writing, without penalty or payment of a termination fee, at any time or after notice as specified in the agreement.

(b) The notice of termination described in subdivision (b)(1)(A)(ii)(a) of this section shall not exceed sixty (60) days;

(iii) Describes the healthcare services to be provided in exchange for payment of a periodic fee;

(iv) Specifies the periodic fee required and any additional fees that may be charged;

(v) May allow the periodic fee and any additional fees to be paid by a third party;

(vi) Prohibits the healthcare provider from charging or receiving additional compensation for healthcare services included in the periodic fee; and

(vii) Conspicuously and prominently states that the agreement is not health insurance and does not meet any individual health insurance mandate that may be required by federal law.

(B) A direct healthcare agreement shall provide a written disclaimer on or accompanying an application distributed by or on behalf of an entity offering a direct healthcare agreement that reads, in substance:

“Notice: A direct healthcare agreement is not an insurance policy, and the select medical services as specified under a direct healthcare agreement may not constitute the minimum essential health benefits under federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to, or regulations or guidance issued under, those statutes existing on January 1, 2017. You may be responsible for any payment for medical services not covered by health insurance under your insurer’s statement of benefits policy.”

(C) “Direct healthcare agreement” does not mean a health benefit plan or a health maintenance organization as defined in § 23-76-102; and

(2) “Healthcare sharing ministry” means a faith-based, nonprofit organization that:

(A) Is tax-exempt under the Internal Revenue Code of 1986;

(B) Limits participation to those who are of a similar faith;

(C) Facilitates an arrangement to match participants who have financial or medical needs to participants with the present ability to assist those with financial or medical needs according to criteria established by the healthcare sharing ministry;

(D) Provides for the financial or medical needs of a participant through contributions from one (1) participant to another;

(E) Establishes contribution amounts for participants with no guarantee of return, assumption of risk, or promise to pay qualified medical needs of the participant or of the medical provider performing the service or services for the participant;

(F) Provides a written monthly statement to its participants that lists:

(i) The total dollar amount of qualified needs submitted to the healthcare sharing ministry; and

(ii) The amount of contribution established for its participants;

(G) Provides a written disclaimer on or accompanying an application and guideline material distributed by or on behalf of the healthcare sharing ministry that reads, in substance:

“Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills.”; and

(H) Transfers or distributes contribution amounts from one (1) participant to match the qualified medical needs of another participant to whom neither the organization nor the sending participant has an obligation or commitment to pay for any qualified medical needs with its own funds.

History. Acts 1959, No. 148, § 12; A.S.A. 1947, § 66-2012; Acts 2013, No. 1163, § 1; 2015, No. 101, § 1; 2017, No. 1020, § 1; 2021, No. 381, § 1.

Amendments. The 2017 amendment substituted “Direct primary care agreements” for “Concierge service arrangements” or similar language in the section heading and throughout the section; rewrote (b)(1)(A); substituted “January 1, 2017” for “January 2, 2015” in (b)(1)(B); inserted (b)(1)(C); and made stylistic changes.

The 2021 amendment substituted “direct healthcare agreement” for “direct primary care agreement” in the section head-

ing and throughout the section; substituted “You may be responsible” for “Medical services provided under a direct primary care agreement may not be covered by or coordinated with your health insurance and you may be responsible” in (b)(1)(B); and made stylistic changes.

U.S. Code. The Internal Revenue Code of 1986, referred to in this section, is codified as 26 U.S.C. § 1 et seq.

Pub. L. No. 111-148, referred to in this section, is the Patient Protection and Affordable Care Act, which is codified throughout Title 42 and other titles of the U.S. Code, including 42 U.S.C. § 300gg et seq. and 42 U.S.C. § 18001 et seq.

23-60-108. Penalty generally.

Unless a greater penalty is provided by another law of this state, a violation of a statute or rule enforceable by the Insurance Commissioner is punishable:

(1) By the refusal, suspension, revocation, or nonrenewal of a license or certificate of authority; and

(2) A fine no greater than one thousand dollars (\$1,000) per violation, not to exceed fifty thousand dollars (\$50,000) in any six-month period.

History. Acts 1959, No. 148, § 15; A.S.A. 1947, § 66-2015; Acts 2009, No. 726, § 4; 2019, No. 315, § 2609.

Amendments. The 2019 amendment substituted “rule” for “regulation” in the introductory language.

23-60-112. American Law Institute — Restatement not public policy.

A statement of the law in the American Law Institute's Restatement of the Law, Liability Insurance does not constitute the public policy of this state if the statement of the law is inconsistent or in conflict with, or otherwise not addressed by:

- (1) A statute of the State of Arkansas;
- (2) The common law and statute law of England as adopted in Arkansas under § 1-2-119; or
- (3) Arkansas case law precedent.

History. Acts 2019, No. 742, § 1.

CHAPTER 61

STATE INSURANCE DEPARTMENT

SUBCHAPTER.

1. GENERAL PROVISIONS.
2. EXAMINATION OF INSURERS, ETC.
3. PROCEEDINGS.
5. JURISDICTION OVER HEALTH BENEFIT PROVIDERS.
6. RISK MANAGEMENT ACT.
7. STATE INSURANCE DEPARTMENT TRUST FUND ACT.
8. ARKANSAS HEALTH INSURANCE MARKETPLACE ACT.
9. ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE ACT OF 2015.
10. ARKANSAS WORKS ACT OF 2016. [EFFECTIVE UNTIL JANUARY 1, 2022.]
10. ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021. [EFFECTIVE JANUARY 1, 2022.]
11. STATE BOARD OF EMBALMERS, FUNERAL DIRECTORS, CEMETERIES, AND BURIAL SERVICES.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

- 23-61-101. State Insurance Department — Continuation — Assignment of space.
- 23-61-102. Insurance Commissioner.
- 23-61-103. Insurance Commissioner — Powers and duties.
- 23-61-104. Deputies, assistants, and other employees — Appointment — Duties.
- 23-61-105. Insurance Commissioner, deputies, assistants, and other employees — Expense allowance.
- 23-61-106. Insurance Commissioner, deputies, assistants, and

SECTION.

- other employees — Financial interest prohibited — Exception.
- 23-61-107. Records.
- 23-61-108. Rules.
- 23-61-112. Annual report.
- 23-61-113. Disclosure of nonpublic personal information.
- 23-61-114. [Repealed.]
- 23-61-115. Policyholder's Bill of Rights.
- 23-61-116. Annual report on health insurance fraud.
- 23-61-117. Risk-based provider organizations.

Preambles. Acts 2017, No. 775, contained a preamble which read:

“WHEREAS, it is beneficial to the

State of Arkansas to be a good steward of public money for sustainable programs for the future; and

"WHEREAS, it is beneficial to the people of the State of Arkansas to recognize the inherent value and contribution of individuals with disabilities; and

"WHEREAS, it is the policy of the State of Arkansas to:

"(1) Respect the rights and privileges conveyed by federal and state law to beneficiaries who are individuals with disabilities;

"(2) Support the right of individuals with disabilities to receive quality services without discrimination; and

"(3) Allow an individual with disabilities to:

"(A) Participate in all decisions regarding his or her care, including the right to refuse treatment, the right to continuity of care, and the right to choose among providers who participate in his or her network; and

"(B) Receive services in his or her local community, or the community of his or her choice, and in the least restrictive setting; and

"WHEREAS, the State of Arkansas wishes to affirm the commitment to the principles of full and equal treatment and unlimited opportunities for all Arkansans that are afforded, as of February 1, 2017, to individuals with disabilities as a basic tenet of this legislation, NOW THEREFORE, ... "

Effective Dates. Acts 2013, No. 1499, § 5: July 1, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the oversight and audit of the state's Medicaid program is essential to its continued operation; that the creation of the Office of the Medicaid Inspector General will ensure that fraud, waste, and abuse are found in a timely manner; and that this act is necessary to ensure that state and federal monies are not misspent. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July, 1, 2013."

Acts 2017, No. 775, § 8: Mar. 31, 2017. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the current method of serving the enrollable Medicaid beneficiary populations is resulting in excessive and unnecessary costs to the Arkansas Medicaid Program and to the

State of Arkansas; that the enrollable Medicaid beneficiary populations are growing at a rate that is unsustainable under the current method of serving the enrollable Medicaid beneficiary populations; that the Medicaid provider-led organized care system will improve quality and efficiencies of healthcare services to enrollable Medicaid beneficiary populations by enhancing the performance of the broader healthcare system with increased access to care; that the Medicaid Provider-Led Organized Care Act requires healthcare providers to create, present to the Department of Human Services and the Insurance Commissioner for approval, implement, and market a new kind of organization that offers a type of health insurance; and that this act is immediately necessary to ensure efficient use of taxpayer dollars and to provide healthcare providers certainty about the law creating the Medicaid Provider-Led Organized Care Act before fully investing time, funds, personnel, and other resources to the development of the new risk-based provider organizations. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled 'Funding and classification of cabinet-level department secretaries' and 'Transformation and Efficiencies Act transition team' should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is

declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019.”

23-61-101. State Insurance Department — Continuation — Assignment of space.

(a)(1) There is created the State Insurance Department.

(2) The State Insurance Department is a division of the Department of Commerce.

(b) Suitable space shall be assigned for the use of the State Insurance Department.

(c)(1)(A) The purpose of the State Insurance Department is to serve and protect the public interest by the equitable enforcement of the state's laws and rules affecting the insurance industry.

(B) The primary mission of the State Insurance Department shall be consumer protection through insurer solvency and market conduct regulation, and fraud prosecution and deterrence.

(2) Nothing in this subsection shall be construed to limit the Insurance Commissioner's authority as enumerated in other provisions of the Arkansas Insurance Code.

History. Acts 1959, No. 148, § 16; A.S.A. 1947, § 66-2101; Acts 2001, No. 610, § 1; 2019, No. 315, § 2610; 2019, No. 910, § 590.

Amendments. The 2019 amendment by No. 315 substituted “rules” for “regulations” in (c)(1)(A).

The 2019 amendment by No. 910 redesignated (a) as (a)(1), substituted “created”

for “continued at the seat of government of this state an office or department designated” in (a)(1), and added (a)(2); and substituted “State Insurance Department” for “department” in (b) and (c)(1)(A) and (c)(1)(B).

23-61-102. Insurance Commissioner.

(a) The head of the State Insurance Department shall be the Insurance Commissioner appointed by the Governor with the advice and consent of the Senate. No person shall be eligible for appointment as commissioner unless a citizen of this state and at least thirty (30) years of age.

(b) The commissioner shall serve at the pleasure of the Governor and shall report to the Secretary of the Department of Commerce.

(c) The commissioner shall take and subscribe to the usual oath of office.

(d) The commissioner shall receive the salary provided by law.

(e)(1) At the time of taking office, the commissioner shall execute bond to the State of Arkansas in the sum of fifty thousand dollars (\$50,000) for the faithful performance of his or her duties.

(2) The form and surety of the bond shall be subject to the approval of the Secretary of the Department of Commerce and the Auditor of State.

(3) An authorized surety insurer shall be the surety on the bond.

(f)(1) The commissioner shall have an official seal.

(2) All certificates issued by the commissioner shall bear his or her seal.

(3) Every document executed by the commissioner pursuant to law and bearing his or her official seal shall be received as evidence in any court or other tribunal and may be recorded in the same manner and with like effect as deeds regularly acknowledged.

History. Acts 1959, No. 148, §§ 17, 18; A.S.A. 1947, §§ 66-2102, 66-2103; Acts 2009, No. 149, § 1; 2019, No. 910, §§ 591, 592.

added “and shall report to the Secretary of the Department of Commerce” in (b); substituted “Secretary of the Department of Commerce” for “Governor” in (e)(2); and made stylistic changes.

Amendments. The 2019 amendment

23-61-103. Insurance Commissioner — Powers and duties.

(a) The Insurance Commissioner shall enforce the provisions of the Arkansas Insurance Code and shall execute the duties imposed upon him or her by the Arkansas Insurance Code.

(b) The commissioner shall have the powers and authority expressly conferred upon him or her by or reasonably implied from the provisions of the Arkansas Insurance Code.

(c) The commissioner is authorized to enter into regulatory cooperation and coordination agreements with other governmental regulatory agencies within and outside of this state with respect to the regulation of the business of insurance, including, but not limited to:

(1) Licensing of insurance companies;

(2) Licensing of producers;

(3) Regulation of premium rates and policy forms;

(4) Regulation of insurer solvency and insurance receiverships; and

(5) Other matters relating to the effective regulation of the business of insurance.

(d)(1) The commissioner may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he or she may deem proper to determine whether any person has violated any provision of the Arkansas Insurance Code or to secure information useful in the lawful administration of any such provision. The cost of these additional examinations or investigations shall be borne by the state.

(2) Notwithstanding any other provision of law, active investigatory or examination files as maintained by the State Insurance Department shall be deemed confidential and privileged and shall not be made open to the public until:

(A) The matter under investigation or examination is deemed closed by the commissioner; or

(B) Referred to any law enforcement authority and made subject to public disclosure by the authority.

(3) At such time that any matter investigated or examined has been set for an administrative hearing pursuant to § 23-61-304 or § 25-15-

208, investigation or examination information shall be made available as provided in § 25-15-208.

(4) Unless otherwise exempted by subdivision (d)(5) of this section, actuarial formulas and assumptions certified by a qualified actuary are confidential and privileged when submitted to comply with a rate or form filing requirement of the department, including, but not limited to, any actuarial report:

(A) Required, submitted, or attached to any filing made to the department under § 23-67-211, for rate and form filings of an insurer, or to those submitted under § 23-63-216 for annual statements of an insurer; or

(B) Submitted to the department to comply with any form and rate filing requirement imposed by statute or rule upon licensed insurers, health maintenance organizations, fraternal benefit societies, and hospital and medical service corporations.

(5)(A) Subdivisions (d)(2) and (d)(4) of this section do not prohibit release by the commissioner of active investigatory or examination files:

(i) At the discretion of the commissioner, to a person or persons that the commissioner determines to be aggrieved or affected by the examination or investigation; or

(ii) To state, federal, or local law enforcement or regulatory agencies or private organizations established for tracking or preventing insurance violations, or to the National Association of Insurance Commissioners.

(B) [Repealed.]

(6) Release of active investigatory or examination files under subdivision (d)(5) of this section does not abrogate or modify the confidential nature of investigatory or examination files under subdivision (d)(2) of this section.

(e)(1) The commissioner may delegate to any assistant, deputy, examiner, or employee of the department the exercise or discharge in the commissioner's name of any power, duty, or function, whether ministerial, discretionary, or of whatever character which may be vested by the Arkansas Insurance Code in the commissioner.

(2) The commissioner shall be responsible for the official acts of his or her deputy, assistant, examiner, or employee acting in the commissioner's name and by his or her authority.

(f)(1)(A) To the extent not otherwise governed by the Trade Practices Act, § 23-66-201 et seq., § 23-65-101 et seq., or a law or rule providing specific injunctive powers to the commissioner, if it appears to the commissioner upon sufficient grounds or evidence that any person has engaged in or is about to engage in any act or practice constituting a violation of an insurance law, rule, or order of this state, the commissioner may summarily order the person to cease and desist from the act or practice.

(B)(i) Upon the entry of the cease and desist order under subdivision (f)(1)(A) of this section, the commissioner shall promptly notify the person who is the subject of the order:

- (a) That the order has been entered; and
- (b) Of his or her right to a hearing concerning the order.

(ii) The notification shall include a copy of the order or a detailed statement of the reasons for the order.

(2)(A) A hearing shall be held under § 23-61-301 et seq. on the written request of the person aggrieved by the cease and desist order under subdivision (f)(1)(A) of this section if the request is received by the commissioner within thirty (30) days of the date of the entry of the order or if ordered by the commissioner.

(B) If no hearing is requested and none is ordered by the commissioner, the order shall remain in effect until it is modified or vacated by the commissioner.

(C) If a hearing is requested or ordered, the commissioner after notice and opportunity for hearing:

- (i) May affirm, modify, or vacate the order; and

(ii) Shall conduct the hearing within ten (10) days of the date a hearing is requested or ordered by the commissioner.

(3)(A) After issuance of an order under this subsection, the commissioner may apply to the Pulaski County Circuit Court to temporarily or permanently enjoin the act or practice and to enforce compliance with the insurance laws of this state.

(B) However, without issuing such an order, the commissioner may apply directly to the Pulaski County Circuit Court for relief.

(4) Upon a proper showing, a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted.

(5)(A) The commissioner may also seek and the appropriate court shall grant, upon proper showing, any other ancillary relief that may be in the public interest.

(B) The relief may include:

(i) The appointment of a receiver, temporary receiver, or conservator;

(ii) A declaratory judgment;

(iii) An accounting;

(iv) A disgorgement of profits;

(v) The assessment of a fine not to exceed the total amount of money, property, or other value received in connection with an insurance law violation; or

(vi) Any other relief appropriate to protect the public interest.

(6) The commissioner is not required to post a bond as a condition for obtaining relief under this subsection.

(7) This subsection does not prohibit or restrict the informal disposition of a proceeding or allegations that might give rise to a proceeding by stipulation, settlement, consent, or default in lieu of a formal or informal hearing on the allegations or in lieu of the sanctions authorized by this subsection.

History. Acts 1959, No. 148, §§ 22, 25; 2001, No. 1239, § 2; 2009, No. 717, § 1; A.S.A. 1947, §§ 66-2107, 66-2110; Acts 2009, No. 726, § 5; 2015, No. 1210, § 1. 1997, No. 956, § 1; 1999, No. 453, § 1;

23-61-104. Deputies, assistants, and other employees — Appointment — Duties.

(a) The Insurance Commissioner, in consultation with the Secretary of the Department of Commerce, may appoint such assistants and deputies and such examiners, attorneys, clerks, stenographers, and other personnel as may be necessary to assist him or her in the discharge of the duties imposed upon him or her under the Arkansas Insurance Code and as may be authorized by law. All such personnel shall devote their entire business time to their duties in the State Insurance Department.

(b) The commissioner, in consultation with the Secretary of the Department of Commerce, may employ an actuary on a consulting or full-time basis to perform such duties as the commissioner may designate.

(c) The commissioner, in consultation with the Secretary of the Department of Commerce, may at any time terminate the appointment, designation, or employment of any assistant, deputy, examiner, attorney, actuary, clerk, or other employee.

(d) The compensation for all such personnel so appointed or employed shall be as fixed by law.

(e) The commissioner, in consultation with the Secretary of the Department of Commerce, may contract for and procure on a basis of fee such independently contracting examination, actuarial, technical, and other professional services as he or she may from time to time require for the discharge of his or her duties.

History. Acts 1959, No. 148, § 19; inserted "in consultation with the Secretary of the Department of Commerce" in A.S.A. 1947, § 66-2104; Acts 2001, No. 1604, § 3; 2019, No. 910, § 593. (a), (b), (c), and (e).

Amendments. The 2019 amendment

23-61-105. Insurance Commissioner, deputies, assistants, and other employees — Expense allowance.

(a) In addition to compensation for their services, the Insurance Commissioner, his or her deputies, assistants, and other Department of Commerce employees performing duties or working within the State Insurance Department shall be paid their actual and necessary expenses as authorized by the commissioner and incurred by them in the performance of their duties, subject to such limitations as may be otherwise applicable pursuant to law.

(b) An itemized statement of all expenses for which payment is being claimed shall be certified by the claimant and attached to the expense voucher.

History. Acts 1959, No. 148, § 20; A.S.A. 1947, § 66-2105; Acts 2019, No. 910, § 594.

Amendments. The 2019 amendment substituted “Insurance Commissioner” for

“Commissioner” in the section heading; and substituted “Department of Commerce employees performing duties or working within the State Insurance Department” for “employees” in (a).

23-61-106. Insurance Commissioner, deputies, assistants, and other employees — Financial interest prohibited — Exception.

(a) The Insurance Commissioner, any deputy, examiner, assistant, or employee of the commissioner, or any employee of the Department of Commerce working for the State Insurance Department shall not be financially interested, directly or indirectly, in any insurer, insurance agency, or insurance transaction, except as:

(1) A policyholder or claimant under a policy;

(2) A grantor of a mortgage or similar instrument on the person’s residence to an entity regulated under the Arkansas Insurance Code if done under customary terms and in the ordinary course of business; or

(3) A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed, provided that the commissioner may make reasonable exceptions upon full and complete written disclosure to the commissioner of the exact nature and extent of the otherwise impermissible financial interest and adhering to any and all reasonable restrictions as the commissioner may impose upon the terms and conditions of employment.

(b) Notwithstanding the requirements of subsection (a) of this section, the commissioner may employ or retain, from time to time, insurance actuaries, technicians, or other professional personnel who are independently practicing their professions even though similarly employed or retained by insurers or others.

(c) The commissioner, any assistant, deputy, examiner, or other employee of the commissioner, or any employee of the Department of Commerce working for the State Insurance Department shall not be given nor receive any fee, compensation, loan, gift, or other thing of value in addition to the compensation and expense allowance provided pursuant to law for any service rendered or to be rendered as commissioner, deputy, examiner, or employee, or in connection therewith.

History. Acts 1959, No. 148, § 21; A.S.A. 1947, § 66-2106; Acts 1991, No. 723, § 1; 1999, No. 304, § 1; 2001, No. 1604, § 4; 2019, No. 910, § 595.

Amendments. The 2019 amendment substituted “Insurance Commissioner” for “Commissioner” in the section heading;

and, in the introductory paragraph of (a) and (c), deleted “or” preceding “any deputy” near the beginning and inserted “or any employee of the Department of Commerce working for the State Insurance Department”.

23-61-107. Records.

(a)(1) The Insurance Commissioner shall enter, in permanent form, records of his or her official transactions, examinations, investigations, and proceedings and keep these records in his or her office.

(2) These records and insurance filings in his or her office shall be open to public inspection, except as otherwise provided in the Arkansas Insurance Code with respect to particular records or filings.

(3) Confidential data and reports provided to the commissioner by the National Association of Insurance Commissioners, including, but not limited to, insurers' Insurance Regulatory Information System ratios and examiner team synopses, shall be deemed privileged communications. These data and reports shall not be open to public inspection and shall not be admissible in evidence in any action or proceeding, other than those brought by the commissioner, nor shall any insurers, agents, or brokers, which may be the subject of the confidential reports, have a cause of action against the commissioner or his or her deputies, examiners, assistants, or employees or against the National Association of Insurance Commissioners, or its members, subscribers, officers, directors, assistants, or employees by reason of the furnishing of any such information to the commissioner.

(4) The commissioner shall maintain as confidential, and not subject to subpoena, financial information regarding material transactions of insurers, as defined in § 23-63-1403 or other applicable laws or rules promulgated by the commissioner.

(5)(A) In order to assist in the performance of the commissioner's duties, the commissioner may:

(i) Share documents, materials, or other information, including confidential and privileged documents, materials, or information, with other state, federal, and international regulatory and legislative agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(ii) Receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory, legislative, and law enforcement officials of other foreign, alien, or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(iii) Enter into agreements governing sharing and use of information consistent with this subsection.

(B) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of

disclosure to the commissioner under this section or as a result of sharing as authorized by this subsection.

(C) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(b) The commissioner may destroy or otherwise dispose of records and filings in his or her office in accordance with such rules and procedures as provided by other applicable laws.

(c)(1) Upon request of any person and upon payment of the applicable fee, the commissioner shall give a certified copy of any record in his or her office which is then open to public inspection.

(2) Copies of original records or documents in his or her office certified by the commissioner shall be received in evidence in all courts as if they were originals.

(3) The commissioner's certificate as to the authority of any person to transact insurance shall be evidence in all courts of the facts set forth therein.

(d) In lieu of original signatures of records and filings, as required by pertinent provisions of the Arkansas Insurance Code, which are permitted to be reproduced in electronic, diskette, or computer-readable form acceptable to the commissioner, the commissioner in his or her discretion may accept electronic, electronic facsimile-transmitted, or computer-readable signatures subject to such conditions and terms as he or she may determine.

History. Acts 1959, No. 148, §§ 23, 24; A.S.A. 1947, §§ 66-2108, 66-2109; Acts 1987, No. 456, § 1; 1995, No. 1272, § 2; 1999, No. 119, § 1; 2001, No. 538, § 1; 2001, No. 1604, §§ 5, 6; 2019, No. 315, § 2611.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (a)(4).

23-61-108. Rules.

(a)(1) The Insurance Commissioner, in consultation with the Secretary of the Department of Commerce, may make reasonable rules necessary for or as an aid to the effectuation of any provision of the Arkansas Insurance Code.

(2) No rule shall extend, modify, or conflict with any law of this state or the reasonable implications thereof.

(3) Any rule affecting persons or matters other than the personnel or the internal affairs of the commissioner's office shall be made or amended only after a hearing thereon of which notice was given as required by § 23-61-304.

(4) If reasonably possible, the commissioner shall set forth the proposed rule or amendment in or with the notice of hearing.

(5) No rule as to which a hearing is required under this subsection shall be effective until after it has been on file as a public record in the

commissioner's office, and otherwise as provided by law, for at least ten (10) days.

(b)(1) The commissioner, in consultation with the Secretary of the Department of Commerce, shall have the authority to promulgate rules necessary for the effective regulation of the business of insurance or as required for this state to be in compliance with federal laws.

(2) The commissioner shall have the authority to coordinate regulatory activities and administration with other states and their appropriate regulatory officials and with the federal government with respect to the regulation of insurance.

(c) In addition to any other penalty provided, willful violation of any rule shall subject the violator to such denial, suspension, or revocation of certificate of authority or license as may be applicable under the Arkansas Insurance Code for violation of the provision to which the rule relates.

(d)(1) The commissioner is authorized to employ the standards and requirements set forth in publications recited in the Arkansas Insurance Code, as those publications existed on January 1, 2001, and adopted and published by the National Association of Insurance Commissioners or by other authors in the regulation of insurance, including, but not limited to, the Valuation of Securities Manual, the examiners handbook, the Accounting Practices and Procedures Manual, and the Annual Statement Instructions as published by the National Association of Insurance Commissioners.

(2) The publications identified in subdivision (d)(1) of this section and others recited in and throughout § 23-60-101 et seq. are hereby adopted as they existed on January 1, 2001.

(3) The commissioner is authorized and empowered to promulgate rules for the purposes of adopting all or part of other publications of the National Association of Insurance Commissioners or publications by other authors if the commissioner determines that such an action is in the best interest of the public.

(4) Upon the mailing of written notice by the commissioner to all domestic reporting entities of promulgation and publication by the National Association of Insurance Commissioners or other authors of amendments, revisions, or modifications to any publication previously adopted by the commissioner in the Arkansas Insurance Code, such published amendments, revisions, or modifications shall become effective on the date designated by the commissioner in the written notice, which date shall not be earlier than eight (8) months after the date of mailing of the notice.

(e) The commissioner is authorized and empowered to adopt rules for the purpose of modifying, amending, or revising any publication promulgated by the National Association of Insurance Commissioners or other authors, or any published amendments, modifications, or revisions to any such publications if the commissioner determines that such an action is in the best interest of the public. In such an event the effective date of any modification, amendment, or revision shall be the effective date of the rule.

History. Acts 1959, No. 148, § 26; A.S.A. 1947, § 66-2111; Acts 2001, No. 1239, § 1; 2001, No. 1604, § 7; 2019, No. 315, § 2612; 2019, No. 910, §§ 596, 597.

Amendments. The 2019 amendment by No. 315 deleted “and regulations” following “rules” in the section heading, in (a)(1), and in (b)(1); deleted “or regulation” following “rule” in (a)(2) through (a)(5),

and in (c) twice; substituted “rules” for “regulations” in (d)(3) and in the first sentence of (e); and substituted “rule” for “regulation” in the last sentence of (e).

The 2019 amendment by No. 910 inserted “in consultation with the Secretary of the Department of Commerce” in (a)(1) and (b)(1).

23-61-112. Annual report.

(a) As early in the calendar year as reasonably possible, the Insurance Commissioner annually shall prepare and deliver a report to the Secretary of the Department of Commerce showing, with respect to the preceding calendar year:

(1) Names of the authorized insurers transacting insurance in this state, with a summary of their financial statements that the commissioner considers proper;

(2) Names of admitted insurers that closed during the year or entered liquidation, a concise statement concerning the cause for each proceeding, and the amount of assets and liabilities as ascertainable;

(3) The total receipts and expenses of the State Insurance Department for the year; and

(4) Other pertinent information and matters the commissioner considers proper.

(b) If the information required under subsection (a) of this section is contained on the state or the department's website under § 25-19-108 or the Arkansas Financial Transparency Act, § 25-1-401 et seq., the report may refer to the web address where the information is located.

History. Acts 1959, No. 148, § 29; A.S.A. 1947, § 66-2114; Acts 2013, No. 355, § 1; 2015, No. 1164, § 1; 2019, No. 910, § 598.

Amendments. The 2019 amendment substituted “Secretary of the Department of Commerce” for “Governor” in the introductory language of (a).

23-61-113. Disclosure of nonpublic personal information.

(a) A person shall not disclose any nonpublic personal information contrary to the provisions of Title V of the Gramm-Leach-Bliley Act, Pub. L. No. 106-102.

(b)(1) The Insurance Commissioner shall adopt rules governing the treatment of consumer financial and protected health information by the Arkansas Comprehensive Health Insurance Pool and by all licensed insurers, health maintenance organizations, or other insuring health entities regulated by the commissioner, producers, and other persons licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered by the commissioner.

(2)(A) An entity or person described in subdivision (b)(1) of this section or a legal entity engaged in the business of insurance, including without limitation an individual, corporation, association,

partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, agent, broker, and adjuster, shall:

(i) Provide notification of a data breach to the commissioner in the same time and manner as required under § 4-110-105; and

(ii) Comply with all requirements for disclosure and notification of a data breach as required under § 4-110-105.

(B)(i) This section does not affect the right of the commissioner to impose other penalties provided for in the insurance laws of this state.

(ii) The commissioner may promulgate rules necessary for or as an aid to the effectuation of any provision of the Arkansas Insurance Code.

(c)(1) The commissioner shall waive any provision of this section that creates a conflict with similar federal laws or regulations, or which, due to the enactment of any similar federal laws or regulations, creates an undue burden or increased financial or operational demands upon a person or entity described in subdivision (b)(1) of this section in order to comply with this section, the rules to be promulgated by the commissioner, and similar federal laws and regulations.

(2) A person or entity described in subdivision (b)(1) of this section may request a hearing before the commissioner to seek the waiver referenced in subdivision (c)(1) of this section.

(3)(A) Under § 23-61-307, a person or entity described in subdivision (b)(1) of this section is entitled to appeal the commissioner's decision to deny a waiver.

(B) In an appeal under this section, the commissioner shall be named as defendant.

(C) In any such action, the commissioner may defend the action in his or her discretion.

History. Acts 2001, No. 1619, § 1; 2005, No. 506, § 9; 2017, No. 283, § 4.

Publisher's Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No.

148. Acts 1959, No. 148, is codified as set out in the note following § 23-60-101.

Amendments. The 2017 amendment rewrote the section.

23-61-114. [Repealed.]

Publisher's Notes. This section, concerning the annual report regarding malpractice rates, was repealed by Acts 2019,

No. 521, § 3, effective July 24, 2019. The section was derived from Acts 2003, No. 1007, § 1.

23-61-115. Policyholder's Bill of Rights.

(a) The principles expressed in subsection (b) of this section shall serve as standards to be followed by the Insurance Commissioner in:

- (1) Exercising the commissioner's powers and duties;
- (2) Exercising administrative discretion;
- (3) Dispensing administrative interpretations of the law; and
- (4) Adopting rules.

(b) Policyholders have the right to:

- (1) Competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies;
- (2) Insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy;
- (3) An insurer that is financially stable;
- (4) Be serviced by a competent, honest insurance producer;
- (5) A readable policy;
- (6) An insurer that provides an economic delivery of coverage and that tries to prevent losses;
- (7) Balanced and positive regulation by the State Insurance Department; and
- (8) A reasonable expectation that the policyholder's nonpublic personal information is securely maintained.

(c) This section shall not be construed as creating, extinguishing, repealing, or limiting any civil cause of action.

History. Acts 2005, No. 1697, § 2; in the introductory language of (b); and
2017, No. 283, § 5; 2019, No. 315, § 2613. added (b)(8).

Amendments. The 2017 amendment The 2019 amendment deleted "and
deleted "shall" following "Policyholders" regulations" following "rules" in (a)(4).

23-61-116. Annual report on health insurance fraud.

Annually on or before March 1, the Insurance Commissioner shall submit to the Secretary of the Department of Commerce, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Attorney General a report summarizing the State Insurance Department's activities to investigate and combat health insurance fraud, including without limitation information regarding:

- (1) Referrals received;
- (2) Investigations initiated;
- (3) Investigations completed; and
- (4) Other material necessary or desirable to evaluate the department's efforts under this section.

History. Acts 2013, No. 1499, § 3; substituted "Secretary of the Department
2019, No. 910, § 599. of Commerce" for "Governor" in the introductory language.

Amendments. The 2019 amendment

23-61-117. Risk-based provider organizations.

(a) The Insurance Commissioner shall regulate the licensing and financial solvency of risk-based provider organizations, as defined in § 20-77-2703, participating in the Medicaid provider-led organized care system for enrollable Medicaid beneficiary populations as defined in § 20-77-2703.

(b) The commissioner may:

- (1) Issue rules to implement this section;

(2) Impose and collect a reasonable fee from a risk-based provider organization for the regulation and licensing of the risk-based provider organization as established by rule of the State Insurance Department; and

(3)(A) Administer collection of the quarterly tax imposed on risk-based provider organizations under § 26-57-603 pursuant to a rule issued by the department.

(B) The commissioner shall prescribe the reporting, forms, and requirements related to the payment of the quarterly tax in a rule issued by the department.

History. Acts 2017, No. 775, § 3.

A.C.R.C. Notes. Acts 2017, No. 802, § 1, provided: "Medicaid provider-led organized care implementation and program savings plan.

"(a)(1) The Department of Human Services shall develop a five-year program savings plan to monitor all Medicaid savings realized by the department, including savings achieved through the delivery of healthcare by risk-based provider organizations within the Arkansas Medicaid Program.

"(2) The five-year program savings plan shall measure:

"(A) Increased care management and care coordination;

"(B) Value-based purchasing strategies;

"(C) Reductions in duplication of healthcare services;

"(D) Reductions in delivery of unnecessary healthcare services;

"(E) The degree of risk assumed by risk-based provider organizations; and

"(F) The amount of projected savings realized as part of the eight hundred thirty-five million dollars (\$835,000,000) in savings requested by the Governor.

"(b)(1) On and after September 1, 2017, the department shall report quarterly on the five-year savings plan to the Legislative Council, the Bureau of Legislative Research, and Arkansas Legislative Audit.

"(2) The initial report shall define projected net savings to the Arkansas Medicaid Program to trend on a quarterly basis to serve as the baseline for measuring the success of implementation and continuing operation, including success attributed to the Medicaid provider-led organized care system.

"(c)(1) If project savings in an amount less than five percent (5%) of the goal are not achieved during any two (2) consecutive quarters unrelated to nonclaims based performance, the department shall develop additional reforms to achieve the savings goals.

"(2) If legislative action is required to implement the additional reforms described in subdivision (c)(1) of this section, the department may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action."

SUBCHAPTER 2 — EXAMINATION OF INSURERS, ETC.

SECTION.

23-61-205. Examination reports.

23-61-206. Examination expense.

23-61-205. Examination reports.

(a)(1) The Insurance Commissioner or his or her examiner shall make a full and true written report of each examination, which shall comprise only facts appearing upon the books, records, or other documents of the insurer, its agents, or other persons examined, or as ascertained from the sworn testimony of its officers or agents or other persons examined concerning its affairs, and shall include such conclu-

sions and recommendations as may reasonably be warranted from the facts.

(2) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the State Insurance Department a verified written report of the examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within thirty (30) days after the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiners' work papers, and enter an order:

(A) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such a violation;

(B) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information, and refile pursuant to subdivision (a)(2) of this section; or

(C) Calling for an investigatory hearing with no less than twenty (20) days' notice to the company for purposes of obtaining additional documentation, data, information, and testimony.

(b)(1) All orders entered pursuant to subdivision (a)(3)(A) of this section shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed, pursuant to § 23-61-307, and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within twenty (20) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) Any hearing conducted under subdivision (a)(3)(C) of this section by the commissioner or authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Within thirty (30) days of the conclusion of any such hearing, the commissioner shall enter an order pursuant to subdivision (a)(3)(A) of this section.

(3) The hearing shall proceed expeditiously with discovery by the company limited to the examiner's work papers which tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation, whether under the control of the department, the company, or other persons. The documents produced shall be included in the record, and testimony taken by the commissioner or his or her representative shall be under oath and preserved for the record at the cost of the company. Nothing contained herein shall require the department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(c)(1) Upon the adoption of the examination report under subdivision (a)(3)(A) of this section, the commissioner shall continue to hold the content of the examination report as private and confidential information for thirty (30) days from the date the company received the order issued by the commissioner to adopt the examination report, except as provided in subdivision (a)(2) of this section.

(2) After the expiration of thirty (30) days, the commissioner may open the report for public inspection if a court of competent jurisdiction has not stayed its publication.

(d) Nothing contained in this subchapter shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this subchapter.

History. Acts 1959, No. 148, § 34; A.S.A. 1947, § 66-2119; Acts 1991, No. 723, § 6; 2005, No. 506, §§ 7, 8; 2017, No. 283, § 6; 2019, No. 315, § 2614.

Amendments. The 2017 amendment added the (c)(1) and (c)(2) designations; in (c)(1), substituted "thirty (30) days from the date the company received" for "a period of thirty (30) days from the date the company received by United States mail

or by electronic mail" and "as provided" for "to the extent provided"; and, in (c)(2), substituted "After the expiration of thirty (30) days, the" for "Thereafter the" and "if a court of competent jurisdiction has not" for "so long as no court of competent jurisdiction has".

The 2019 amendment substituted "rule" for "regulation" in (a)(3)(A).

23-61-206. Examination expense.

(a)(1) Each person examined shall pay to the State Insurance Department the actual travel expenses, reasonable living expense allowance, and compensation for examiners and other persons assisting in the examination according to the examination guidance section in the

most current edition of the examiners handbook adopted by the National Association of Insurance Commissioners.

(2) Except as provided in subdivision (a)(1) of this section, the cost of independent professionals used as examiners to assist in an examination under subsection (b) of this section is paid directly by the person examined.

(b)(1) Payments for travel expenses and living expense allowance received by the department for each examination shall be deposited as cash funds.

(2) Reimbursement shall be made from these funds to examiners and others assisting in the examination.

(3) Per diem charges of examiners and others assisting in the examination shall be computed beginning at the time of reporting for duty at the office of the company to be examined and terminating upon completion of the examination or the examiner's active participation therein and to include actual days for travel as certified by the Insurance Commissioner. If air travel is used, only one (1) day's travel time will be authorized. If an automobile is used, travel time allowed shall be computed at the rate of not less than four hundred (400) miles per day as determined by the Rand McNally Road Atlas, with the actual mileage traveled compensated at the most current rate per mile approved for state employees.

(4) Examiners and others assisting in the examination shall not be reimbursed for travel time or travel expenses not actually incurred in connection with an assignment, nor shall they be reimbursed for dual living expenses while on branch office assignments.

(5) Examiners and others assisting in the examination, when participating in or conducting an examination of a foreign company, shall be authorized to return to their state of domicile every other weekend. Their expenses will be paid based upon the lesser of airfare or mileage. The reimbursement shall be made in lieu of the per diem allowance. The travel shall be accomplished with a minimum amount of work time lost.

(c) Payments for employee compensation received by the department shall be deposited by the commissioner into the State Treasury to be credited to the State Insurance Department Trust Fund used for the maintenance, operation, and support of the department.

(d) No person shall pay, and no examiner shall accept, any additional emolument on account of any examination.

History. Acts 1959, No. 148, § 35; 2120; Acts 1991, No. 723, § 7; 1999, No. 1967, No. 433, § 1; 1977, No. 789, § 1; 881, § 5; 2007, No. 496, § 3; 2013, No. 1983, No. 454, § 1; A.S.A. 1947, § 66-355, § 2.

SUBCHAPTER 3 — PROCEEDINGS

SECTION.

23-61-302. Examination, investigation, or hearing — Testimony compelled.

SECTION.

23-61-303. Hearing — Generally.

23-61-302. Examination, investigation, or hearing — Testimony compelled.

(a)(1) An individual may execute, acknowledge, and file in the State Insurance Department a statement expressly waiving immunity or privilege for any transaction, matter, or thing specified in the statement.

(2) If a statement is filed under subdivision (a)(1) of this section, the testimony of the person or the evidence in relation to the transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise.

(b) If testimony or evidence is received or produced under subdivision (a)(2) of this section, the individual is not entitled to any immunity or privilege on account of any testimony he or she may give or evidence produced.

History. Acts 1959, No. 148, § 37; A.S.A. 1947, § 66-2122; Acts 2017, No. 283, § 7. deleted “Immunity from prosecution” from the section heading; deleted former (a); and rewrote former (b)(1) as (a)(1) and (2) and former (b)(2) as (b).

Amendments. The 2017 amendment

23-61-303. Hearing — Generally.

(a) The Insurance Commissioner may hold hearings for any purpose within the scope of the insurance laws of this state.

(b)(1) The commissioner shall hold a hearing if required by any provision or upon written demand for a hearing by a person aggrieved by any act, threatened act, or failure of the commissioner to act, or by any report, rule, or order of the commissioner, other than an order for the holding of a hearing, or an order on hearing or pursuant thereto.

(2) Any demand shall specify the grounds to be relied upon as a basis for the relief to be demanded at the hearing, and unless postponed by mutual consent, the hearing shall be held within thirty (30) days after receipt by the commissioner of the demand.

(3) If the commissioner has a conflict or is otherwise unable to serve, the commissioner may appoint and compensate a person, including without limitation an attorney or retired judge, from outside the State Insurance Department to act as a hearing officer.

(c) Pending the hearing and decision thereon, the commissioner may suspend or postpone the effective date of the commissioner’s previous action.

History. Acts 1959, No. 148, § 38; 1979, No. 942, § 2; A.S.A. 1947, § 66-2123; Acts 2011, No. 760, § 1; 2019, No. 315, § 2615.

Amendments. The 2019 amendment deleted “regulation” following “rule” in (b)(1).

23-61-304. Hearing — Notice.

CASE NOTES

Notice Sufficient.

Revocation of an insurance license was upheld because hearing notice sent by the Arkansas Insurance Department provided sufficient warnings of the allegations against a title insurance company owner; a detailed description of the precise instances of misconduct was not re-

quired. The notice plainly charged the owner with diverting or misappropriating escrow funds, and it reasonably informed the owner of the type of violations that were later cited in the Department’s order as a basis for revocation. *Dyer v. Ark. Ins. Dep’t*, 2015 Ark. App. 446, 468 S.W.3d 303 (2015).

SUBCHAPTER 5 — JURISDICTION OVER HEALTH BENEFIT PROVIDERS

SECTION.

23-61-502. Exempt healthcare plans.

23-61-508. Rules.

23-61-502. Exempt healthcare plans.

The provisions of this subchapter shall not apply to those healthcare plans which are maintained:

- (1) Pursuant to a collective bargaining agreement;
- (2) By a tax exempt rural electric cooperative;
- (3) By The Poultry Federation; or

(4) By any nonprofit vision service plan corporation composed of at least fifty (50) participating optometrists or ophthalmologists licensed by the State of Arkansas to provide vision care services on a prepaid basis when each licensed optometrist or ophthalmologist is subject to the rules of the professional’s respective state board and when each participating licensed optometrist or ophthalmologist agrees to assume responsibility for completion of the provisions of the vision care services contracted for so that no element of risk is incurred by any subscriber group or person.

History. Acts 1983, No. 728, § 8; 1985, No. 794, § 1; A.S.A. 1947, § 66-2026; Acts 2019, No. 315, § 2616.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in (4).

23-61-508. Rules.

The Insurance Commissioner is authorized to promulgate rules which may be necessary for the implementation and enforcement of this subchapter.

History. Acts 1983, No. 728, § 7; A.S.A. 1947, § 66-2025; Acts 2019, No. 315, § 2617.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in the section heading and in the text.

SUBCHAPTER 6 — RISK MANAGEMENT ACT

SECTION.

23-61-606. Procurement of insurance or surety bonding.

SECTION.

23-61-607. Rules.

23-61-606. Procurement of insurance or surety bonding.

(a) The State Procurement Director shall procure insurance or surety bonding in accordance with the Arkansas Procurement Law, § 19-11-201 et seq., unless the risk manager determines that it is in the best interest of the state for the director to procure insurance or surety bonding by negotiation, or for any state agency to procure all or part of its own insurance or surety bonding.

(b) When the Administrator of the Risk Management Division authorizes state agencies to procure insurance or surety bonding, the authorization shall be made in writing and approved by the Insurance Commissioner. The authorization may be made for, but not limited to, purchases not exceeding an amount established by rules, particular lines of insurance, and purchases by state agencies with a demonstrated expertise in the field of risk management.

(c) Upon approval of the risk manager and the director, a state agency may be authorized to procure insurance or surety bonding under emergency conditions. Emergency conditions exist when life, health, welfare, assets, or functional operations of an agency are or may be threatened or impaired.

(d) The director shall not have jurisdiction over the procurement of surety bonding or insurance coverage for state agencies except as provided by this subchapter.

History. Acts 1981, No. 272, §§ 7-10; 1983, No. 522, §§ 41, 42; A.S.A. 1947, §§ 66-5707 — 66-5710; Acts 2019, No. 315, § 2618.

Amendments. The 2019 amendment substituted “rules” for “regulations” in the second sentence of (b).

23-61-607. Rules.

(a) The Administrator of the Risk Management Division shall have the authority to promulgate rules consistent with this subchapter.

(b) All rules shall be subject to the approval of the Insurance Commissioner and conform with the requirements of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1981, No. 272, § 11; A.S.A. 1947, § 66-5711; Acts 2019, No. 315, § 2619.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in the section heading, in (a), and in (b).

SUBCHAPTER 7 — STATE INSURANCE DEPARTMENT TRUST FUND ACT

SECTION.

- 23-61-706. Administrative and regulatory fees — Other licensees.
- 23-61-707. [Repealed.]
- 23-61-708. Fees for various other departmental services and products.

SECTION.

- 23-61-709. Insurance Commissioner's authority, powers, and duties.
- 23-61-710. Trust fund — State Insurance Department vouchers and Auditor of State.

Effective Dates. Acts 2015, No. 871, § 35: Apr. 1, 2015. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a one (1) year period; that the effectiveness of this Act on July 1, 2015 is essential to the operation of the agency for which the appropriations in this Act are provided; with the exception that SECTIONS 28, 31 and 32 in this Act shall be in full force and effect from and after the date of its passage and approval and SECTIONS 29 and 30 shall be in full force and effect from and after January 1, 2015, and that in the event of an extension of the Legislative Session, the delay in the effective date of this Act beyond July 1, 2015, with the

exception that SECTIONS 28, 31 and 32 in this Act shall be in full force and effect from and after the date of its passage and approval and SECTIONS 29 and 30 shall be in full force and effect from and after January 1, 2015, could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2015; with the exceptions that SECTIONS 28, 31 and 32 in this Act shall be in full force and effect from and after the date of its passage and approval and SECTIONS 29 and 30 shall be in full force and effect from and after January 1, 2015."

23-61-706. Administrative and regulatory fees — Other licensees.

(a) In addition to and notwithstanding all other current and future statutory fees, assessments, or penalties paid by licensees or registrants in connection with the issuance and renewal of their Arkansas licenses or registrations as required under the Arkansas Insurance Code or other Arkansas laws, new and additional or increased nonrefundable administrative and regulatory fees are hereby imposed against all licensed resident and nonresident agents, agencies, brokers, surplus line and purchasing group brokers, risk retention agents, third party administrators, and similar licensees or registrants for each and every individual, firm, or corporation licensed or registered by the State Insurance Department pursuant to the provisions of the Arkansas Insurance Code and, in particular, the provisions of § 23-64-101 et seq., § 23-64-201 et seq., the Surplus Lines Insurance Law, § 23-65-301 et seq., § 23-73-101 et seq., § 23-74-101 et seq., § 23-76-101 et seq., the Arkansas Legal Insurance Act, § 23-91-201 et seq., § 23-92-201 et seq., and the Risk Retention and Purchasing Groups Act, § 23-94-201 et

seq., excluding insurers, health maintenance organizations, hospital and medical service corporations, fraternal benefit societies, and farmers' mutual aid associations, risk retention and purchasing groups, stipulated premium insurers, and similar insurer-type entities.

(b) The fees shall be payable to the State Insurance Department Trust Fund for the support and operation of the State Insurance Department, and in no event shall any one (1) fee required by subsection (a) of this section exceed a maximum of fifty dollars (\$50.00) per license or registration. The fees due per license as required by this section commencing on and after July 1, 1994, and annually thereafter, shall be due in an amount and at such times or upon such schedule as the Insurance Commissioner shall prescribe in a companion rule to this chapter after notice and a public hearing, so long as the companion rule does not provide for any one (1) fee set pursuant to this section to exceed the maximum amount of fifty dollars (\$50.00) per license.

(c) Commencing immediately on and after March 24, 1993, all new applicants for original or initial licensure or registration pursuant to the provisions of any of the Arkansas Insurance Code subchapters recited in subsection (a) of this section shall pay the annual administrative and regulatory fee per license or registration to accompany the application for the license or registration upon filing with the department.

(d)(1) Upon the failure of the applicant or licensee or registrant timely to report or pay any of the additional administrative and regulatory fees assessed in this section, the fee payable to the State Insurance Department Trust Fund shall be twice the amount required in this section.

(2) Additionally, without an abuse of discretion, the commissioner in his or her discretion may deny licensure or renewal licensure or registration or renewal registration to a new applicant, licensee, or registrant, or may suspend or revoke current licensees or registrants required by this section to pay the administrative and regulatory fee.

(3) The commissioner may also pursue other civil legal remedies for collection of the fees and penalties due and unpaid from applicants and licensees and registrants pursuant to this section.

(e) Upon collection, the Insurance Commissioner shall deposit all such administrative and regulatory fees and penalties directly into the State Insurance Department Trust Fund as special revenues.

(f) For the licensees enumerated in this section whose licenses are subsequently suspended for violations of Arkansas laws or the commissioner's rules or orders, the administrative and regulatory fees are due and owing upon the normal due date prescribed in the commissioner's companion rule to this subchapter, including those licensees under a license suspension ordered by the commissioner for timely failure to pay this regulatory fee, and license reinstatement shall not proceed, automatically or otherwise, pursuant to the Arkansas Insurance Code unless and until the licensee pays all outstanding and owing regulatory fees imposed by this chapter.

History. Acts 1993, No. 652, § 7; 2019, No. 315, § 2620.

deleted “and regulation” following the first occurrence of “rule” in the second sentence of (b).

Amendments. The 2019 amendment

23-61-707. [Repealed.]

Publisher’s Notes. This section, concerning fees for copies, was repealed by Acts 2021, No. 367, § 9, effective July 28,

2021. The section was derived from Acts 1993, No. 652, § 8; 1999, No. 881, § 7.

23-61-708. Fees for various other departmental services and products.

(a)(1) Notwithstanding other provisions of this subchapter and notwithstanding other provisions of the Arkansas Insurance Code or other applicable Arkansas laws, the Insurance Commissioner shall by companion rule to this subchapter prescribe the amount and manner of payment of new, additional, or increased but nonrefundable fees due as special revenues to the State Insurance Department Trust Fund for the following services, documents, or publications provided by the State Insurance Department, including, but not limited to:

(A) Filing by insurers of each agent appointment termination form;

(B) Application for or issuance of original certification to be a course provider for agent prelicensing or continuing education in this state;

(C) Application for or issuance of renewal certification to be a course provider for agent prelicensing or continuing education in this state;

(D) Filing fees for applications filed for original examinations and retake examinations administered by the department;

(E) Filing of initial and renewal insurer appointments of resident insurance agencies, corporations, or firms and partnerships;

(F) Annual renewal of each certificate of registration issued to a third party administrator;

(G) A filing and processing fee for filing legal process with the department wherein the commissioner is serving as official agent for service of process;

(H) Filing and processing fees for filing specimen insurance policy and contract forms of all types with the department;

(I) A filing fee for obtaining department lists of various kinds of licensees or registrants; and

(J) Similar department services and products.

(2) In the event the commissioner is required by laws enacted contemporaneously with or subsequent to this subchapter to perform other duties or incur other obligations, and in the event current revenues of the department, including, but not limited to, those revenues produced by this subchapter, are not sufficient for the commissioner to perform those new or additional duties efficiently and promptly or to the extent the commissioner deems necessary, then the

commissioner shall enact new or additional or increased fees for departmental services, documents, and publications, but such fees shall only be adopted and imposed in a rule promulgated by the commissioner after notice and a hearing pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and other applicable sections of the Arkansas Insurance Code and other laws.

(3) The fees described in this section and prescribed in amount and frequency of payment in the commissioner's companion rule to this subchapter shall be payable to the State Insurance Department Trust Fund as special revenues for the support and operation of the State Insurance Department.

(b)(1)(A) The fees for various department services, documents, or publications shall be divided into two (2) categories, Category A fees and Category B fees, and shall be so specified in the companion rule to this subchapter.

(B) Category A fees at a maximum of one thousand five hundred dollars (\$1,500) per transaction shall consist of those fees representing material or substantive corporate transactions of licensees, including, but not limited to, holding company changes in control of insurers or similar entities, corporate mergers and consolidation, bulk, or assumptive reinsurance transactions, as well as department products and services which would require a substantial commitment of department resources per transaction.

(C) Category B fees at a maximum of fifty dollars (\$50.00) per transaction shall consist of those fees representing other transactions of licensees, as well as department products and services which would not require a substantial commitment of department resources per transaction.

(2) In no event shall any one (1) Category A fee or Category B fee for any department service, document, or publication per transaction pursuant to this section and the commissioner's companion rule and regulation exceed the maximums listed herein.

(c) The commissioner may from time to time alter the fee amounts by rule amendment pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq., but in no event shall such fee amendments necessary for continued support and operation of the department exceed the limitations set forth in this section.

(d) Insurers obligated to secure or renew agent appointments using department forms one through forty-eight (1-48) for their agent representatives on the licensing records of the State Insurance Department pursuant to the provisions of § 23-64-514 on a new or biennial renewal basis shall no longer collect such licensure expenses, directly or indirectly, from the agent licensee, or exact any form of reimbursement for the statutory appointment fees, or pass such costs along to the agent licensee, directly or indirectly, as any other type of charge, notwithstanding the provision of any agency, brokerage, or employment contract or agreement with the agent to the contrary.

History. Acts 1993, No. 652, § 9; 2001, No. 580, § 2; 2019, No. 315, §§ 2621, 2622.

Amendments. The 2019 amendment deleted “and regulation” following “rule” in (a)(2) and (c).

23-61-709. Insurance Commissioner’s authority, powers, and duties.

(a) The Insurance Commissioner shall be duly authorized to promulgate rules necessary to effectuate the purposes of this subchapter.

(b) Upon his or her determination and finding that State Insurance Department appropriations or funding is insufficient to operate the department efficiently or to allow the commissioner to perform all of his or her statutorily mandated duties and tasks, the commissioner may, in his or her discretion, by rule following notice and a public hearing, increase the amounts of the fees, license fees, fines, penalties, and revenues as provided in this subchapter for deposit into the State Insurance Department Trust Fund as special revenues.

(c)(1) Further, in his or her discretion the commissioner may establish and collect as special revenues additional or increased fees and penalties not otherwise specified in this subchapter, for direct deposit into the State Insurance Department Trust Fund as special revenues if the fees and revenues provided by this subchapter are insufficient, in connection with all other revenues appropriated to and funded for the department, to defray all the expenses of the department in the efficient discharge of its administrative and regulatory powers and duties as prescribed by law.

(2) Any special revenues and fees established by the commissioner by the authority of this section shall be classified in and meet the criteria of the Category A fees or Category B fees specified by § 23-61-708.

(3) Upon collection by the commissioner, these funds shall be deposited as special revenues directly into the State Insurance Department Trust Fund.

(4) The commissioner may from time to time alter the amounts of the fees specified in the companion rules to this subchapter by amending the rules pursuant to the procedures of the Arkansas Administrative Procedure Act, § 25-15-201 et seq., as necessary to the continued support and operation of the department.

History. Acts 1993, No. 652, § 10; 2019, No. 315, § 2623.

deleted “and regulations” following “rules” in (a); and deleted “and regulation” following “rule” in (b).

Amendments. The 2019 amendment

23-61-710. Trust fund — State Insurance Department vouchers and Auditor of State.

(a) All fees, license fees, and additional or increased license or registration fees, fines, penalties, and revenues provided for in this subchapter received as special revenues for the State Insurance Department Trust Fund and deposited therein shall be deemed for all

purposes revenues of the State Insurance Department Trust Fund and of the State Insurance Department for the sole support, operation, and maintenance of the department, and, when paid into the State Treasury by the Insurance Commissioner, shall be maintained by the State Treasury as the State Insurance Department Trust Fund, separate from all other funds, and available only for the payment of the expenses of the department pursuant to the appropriations therefor.

(b) The Auditor of State shall, upon proper voucher from the commissioner, issue his or her warrant on the Treasurer of State in payment of all salaries and other expenses incurred in the administration of this subchapter.

(c) The commissioner shall at the end of each biennium period cause to be transferred into the General Revenue Fund Account of the State Apportionment Fund the excess of the State Insurance Department Trust Fund moneys over an amount equal to one (1) fiscal-year budget for the department.

History. Acts 1993, No. 652, § 11; 1993, No. 901, § 46; 2015, No. 871, § 28.

SUBCHAPTER 8 — ARKANSAS HEALTH INSURANCE MARKETPLACE ACT

SECTION.

23-61-801. Title.

23-61-802. Definitions.

23-61-803. Arkansas Health Insurance Marketplace. [Effective until January 1, 2022.]

23-61-803. Arkansas Health Insurance Marketplace. [Effective January 1, 2022.]

SECTION.

23-61-804. Duties of Arkansas Health Insurance Marketplace.

23-61-805. Funding — Publication of costs.

23-61-806. Rules.

23-61-807. Relation to other laws.

23-61-808. [Repealed.]

A.C.R.C. Notes. Acts 2013, No. 1500, § 3, as amended by identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 3, provided: “The health insurance marketplace developed through a Federally-facilitated Exchange Partnership model shall be under the control of the Arkansas Health Insurance Marketplace.”

Acts 2013, No. 1500, § 4, provided: “Legislative intent. It is the intent of the General Assembly by the enactment of this act to establish a private, nonprofit, health insurance marketplace.”

Acts 2015, No. 398, §§ 1, 2, provided: “SECTION 1. Findings and intent.

“(a) On March 4, 2015, the United States Supreme Court shall hear oral arguments in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475 (2014), that could potentially

change the landscape for implementation of a state-based health insurance exchange and a health insurance exchange operated by the federal government for states without a state-based health insurance exchange under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

“(b) The health insurance marketplace developed through a federally facilitated exchange partnership model is expected to transfer to the control of the Arkansas Health Insurance Marketplace on July 1, 2015, if the Board of Directors of the Arkansas Health Insurance Marketplace determines that the implementation of a state-based health insurance marketplace is approved by the United States Depart-

ment of Health and Human Services on or before July 1, 2015.

“(c) The purpose of this act is to prohibit the implementation through 8 state law of a state-based health insurance exchange in this state under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, before the United States Supreme Court issues a ruling in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475 (2014).

“(d)(1) It is the intent of this act that until a ruling is issued in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475 (2014), that is expected before July 1, 2015, this state should not implement through state law a state-based health insurance exchange in this state.

“(2) If a ruling in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475 (2014), modifies the eligibility requirements for subsidies in a health insurance exchange operated by the federal government under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, a state-based health insurance exchange should not be implemented in this state without the legal authority to establish and operate an exchange under state law and the approval of the General Assembly.

“SECTION 2. Implementation of state-based health insurance exchange.

“(a) A state-based health insurance exchange shall not be implemented in this state until after the decision of the United States Supreme Court in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475 (2014).

“(b) If the Board of Directors of the Arkansas Health Insurance Marketplace determines that the decision in *King v. Burwell*, 759 F.3d 358 35 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475 (2014):

“(1) Allows subsidies under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, for a state-based health insurance exchange, but not for a health insurance exchange operated by the federal government, then implementation of an appropriate health insurance exchange

for the State of Arkansas shall be determined by a future act of the General Assembly; or

“(2) Allows subsidies under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, for both a state-based health insurance exchange and a health insurance exchange operated by the federal government, then the authority of the Arkansas Health Insurance Marketplace to implement a state-based health insurance exchange shall not be affected by this act.”

Acts 2015, No. 871, § 31, provides: “FUNDING RESTRICTIONS. The State Insurance Department shall not allocate, budget, expend or commit for expenditure any appropriation authorized by the General Assembly for final implementation of a state-based health insurance exchange by the Arkansas Health Insurance Marketplace Board as established in Arkansas Code § 23-61-803 et seq. until after the decision of the United States Supreme Court in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _ U.S. _, 135 S. Ct. 475(2014).

“The provisions of this Section shall be in effect from the date of the passage and approval of this Act through June 30, 2016.”

Acts 2016, No. 254, § 27, provided: “HEALTHCARE INDEPENDENCE PROGRAM AND ARKANSAS HEALTH INSURANCE MARKETPLACE RESTRICTIONS.

“(a) As used in this section, ‘Health Care Independence Program’ means the Health Care Independence Program established under the Health Care Independence Act of 2014, Arkansas Code § 20-77-2401 et seq.

“(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the State Insurance Department shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or the Health Care Independence Program, including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements printed in newspapers, magazines, or other print media; and

“(E) Internet websites and electronic media.

“(2) This subsection does not prohibit the department from:

“(A) Direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the individual might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or the Health Care Independence Program.

“(d) The State Insurance Department shall not apply for or accept any funds, including without limitation federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or the Health Care Independence Program.

“(e)(1) Except as provided in subdivision (e)(2) of this section, the State Insurance Department shall not:

“(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

“(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

“(f) An appropriation authorized by the General Assembly shall not be subject to the provisions allowed through reallocation of resources or transfer of appropriation authority for the purpose of transferring an appropriation to any other appropriation authorized for the State Insurance Department to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

“(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

“(h) This section expires on June 30, 2017.”

Acts 2016, No. 254, § 28, provided: “FUNDING RESTRICTIONS. The State Insurance Department shall not allocate, budget, expend or commit for expenditure any appropriation authorized by the General Assembly for final implementation of a state-based health insurance exchange by the Arkansas Health Insurance Marketplace Board as established in Arkansas Code § 23-61-803 et seq. until after the decision of the United States Supreme Court in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _U.S._, 135 S. Ct. 475(2014).”

“The provisions of this section shall be in effect only from July 1, 2016 through June 30, 2017.”

Identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 2, provided: “Study regarding future direction for Arkansas Health Insurance Marketplace.

“(a) The Legislative Council shall:

“(1) Review the operations, programs, and finances of the Arkansas Health Insurance Marketplace;

“(2) Study approaches by other states regarding health insurance marketplace structure, design, and operations;

“(3) Provide recommendations concerning the Arkansas Health Insurance Marketplace for the continued availability of health insurance to Arkansans; and

“(4) Explore and recommend options for the future efficiency and sustainability of the Arkansas Health Insurance Marketplace.

“(b)(1)(A) The Legislative Council shall report on the findings of the items listed in subsection (a) of this section to the General Assembly.

“(B) A copy of the report shall be sent to the Governor.

“(2) The report shall include without limitation recommendations for legislation.

“(c) The Legislative Council may utilize a subcommittee created under § 23-61-803(q)(5)(A) to conduct the study of the items in subsection (a) of this section.”

Acts 2017, No. 833, § 25, provided: “FUNDING RESTRICTIONS. The State Insurance Department shall not allocate, budget, expend or commit for expenditure any appropriation authorized by the General Assembly for final implementation of a state-based health insurance exchange

by the Arkansas Health Insurance Marketplace Board as established in Arkansas Code § 23-61-803 et seq. until after the decision of the United States Supreme Court in *King v. Burwell*, 759 F.3d 358 (4th Cir.), cert. granted, _U.S._, 135 S. Ct. 475(2014).

“The provisions of this section shall be in effect only from July 1, 2017 through June 30, 2018.”

Acts 2017, No. 854, § 22, provided: “ARKANSAS WORKS AND ARKANSAS HEALTH INSURANCE MARKETPLACE RESTRICTIONS.

“(a) As used in this section, ‘Arkansas Works’ means the Arkansas Works established under the Arkansas Works Act of 2016, Arkansas Code § 23-61-1001 et seq.

“(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the Department of Health shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Works, including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements printed in newspapers, magazines, or other print media; and

“(E) Internet websites and electronic media.

“(2) This subsection does not prohibit the department from:

“(A) Direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the individual might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or Arkansas Works.

“(d) The Department of Health shall not apply for or accept any funds, including without limitation federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Works.

“(e)(1) Except as provided in subdivision (e)(2) of this section, the Department of Health shall not:

“(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

“(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

“(f) An appropriation authorized by the General Assembly shall not be subject to the provisions allowed through reallocation of resources or transfer of appropriation authority for the purpose of transferring an appropriation to any other appropriation authorized for the Department of Health to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

“(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

“(h) This section expires on June 30, 2018.”

Acts 2018, No. 234, § 22, provided: “ARKANSAS WORKS AND ARKANSAS HEALTH INSURANCE MARKETPLACE RESTRICTIONS.

“(a) As used in this section, ‘Arkansas Works’ means the Arkansas Works established under the Arkansas Works Act of 2016, Arkansas Code § 23-61-1001 et seq.

“(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Rev-

enue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the Department of Health shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Works, including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements printed in newspapers, magazines, or other print media; and

“(E) Internet websites and electronic media.

“(2) This subsection does not prohibit the department from:

“(A) Direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the individual might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or Arkansas Works.

“(d) The Department of Health shall not apply for or accept any funds, including without limitation federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or

encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Works.

“(e)(1) Except as provided in subdivision (e)(2) of this section, the Department of Health shall not:

“(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

“(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

“(f) An appropriation authorized by the General Assembly shall not be subject to the provisions allowed through reallocation of resources or transfer of appropriation authority for the purpose of transferring an appropriation to any other appropriation authorized for the Department of Health to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

“(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

“(h) This section expires on June 30, 2019.”

Acts 2019, No. 107, § 1, provided: “Abolition of Board of Directors of the Arkansas Health Insurance Marketplace — Transfer of Arkansas Health Insurance

Marketplace to State Insurance Department.

“(a) The Board of Directors of the Arkansas Health Insurance Marketplace is abolished, and its powers, duties, functions, records, contracts, property, unexpended balances of appropriations, allocations, and other funds are transferred to the State Insurance Department.

“(b)(1) The Arkansas Health Insurance Marketplace and its statutory powers, duties, and functions, including the functions of budgeting or purchasing, records, contracts, property, and unexpended balances of appropriations, allocations, and other funds are transferred to the State Insurance Department.

“(2) The Arkansas Health Insurance Marketplace shall operate as a division within the State Insurance Department under the authority of the Insurance Commissioner.

“(3) All existing contracts with either the Arkansas Health Insurance Marketplace or the Board of Directors of the Arkansas Health Insurance Marketplace may be renegotiated by the State Insurance Department.”

Acts 2021, No. 843, § 13, provides: “ARKANSAS HEALTH AND OPPORTUNITY FOR ME AND ARKANSAS HEALTH INSURANCE MARKETPLACE RESTRICTIONS.

“(a) As used in this section, ‘Arkansas Health and Opportunity for Me’ means Arkansas Health and Opportunity for Me established under the Arkansas Health and Opportunity for Me Act of 2021, Arkansas Code § 23-61-1001 et seq.

“(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Rev-

enue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the Department of Human Services shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me, including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements printed in newspapers, magazines, or other print media; and

“(E) Internet websites and electronic media.

“(2) This subsection does not prohibit the department from:

“(A) Direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the individual might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me.

“(d) The Department of Human Services shall not apply for or accept any funds, including without limitation fed-

eral funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me.

“(e)(1) Except as provided in subdivision (e)(2) of this section, the Department of Human Services shall not:

“(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

“(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

“(f) An appropriation authorized by the General Assembly shall not be subject to the provisions allowed through reallocation of resources or transfer of appropriation authority for the purpose of transferring an appropriation to any other appropriation authorized for the Department of Human Services to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

“(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

“(h) This section expires on June 30, 2022.”

Preambles. Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, contained a preamble which read: “WHEREAS, the State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage employer-based insurance, incentivize program beneficiaries to work or seek work opportunities, promote personal responsibility, and enhance program integrity; and

“WHEREAS, the General Assembly affirms its responsibility to safeguard consumers and businesses from federal mandates by asserting local control and implementation of modernized health insurance policies and programs that utilize the private market to improve access to health insurance, enhance the quality of health insurance, and reduce health insurance costs; and

“WHEREAS, Arkansas recognizes the need to encourage employment among beneficiaries of public assistance programs, offer enhanced opportunities for beneficiaries to obtain jobs and job training, and endow beneficiaries with the tools to achieve economic advancement; and

“WHEREAS, the Health Care Independence Program will terminate on December 31, 2016; and

“WHEREAS, the General Assembly hereby creates the Arkansas Works Act of 2016 to provide health insurance to qualifying individuals, NOW THEREFORE, ...”

Effective Dates. Acts 2013, No. 1500, § 5: Apr. 23, 2013. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, allow each state to establish a health insurance marketplace or opt to participate in a health insurance marketplace operated by the United States Department of Health and Human Services; that the state has elected to create a state-based marketplace effective on July 1, 2015; and that this act should become effective at the earliest opportunity to begin the process of planning for the implementation of a state-based marketplace and transitioning to a state-based marketplace. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and

safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2014, No. 282, § 27: July 1, 2014, except §§ 20-23, effective Mar. 13, 2014. Emergency clause provided:

“(a) It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a one (1) year period; that the effectiveness of this Act on July 1, 2014, is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the legislative session, the delay in the effective date of this Act beyond July 1, 2014, could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and Sections 1 through 19 and 24 through 26 of this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2014.

“(b) It is found and determined by the General Assembly of the State of Arkansas that a clarification of voting procedures is necessary to implement the intent of the General Assembly in establishing the Arkansas Health Insurance Marketplace Board of Directors; the maintenance of an appropriate balance to determine the proper course for the Arkansas Health Insurance Marketplace is immediately necessary; that the citizens of this state will be best served by the change in voting procedures of the board required by this act; that the reporting provisions of this act are essential for the assessment and administration of the outcomes-based system mandated by Arkansas Code § 20-47-705 and episodes of care; that in order to meet the deadlines established by this act, the affected providers and state agencies need as much time as possible to assemble and report the required information; and that Sections 20 through 23 of this act are immediately necessary for the administration of important programs and to provide infor-

mation necessary to make reasoned and prudent decisions concerning the provision of health care for the citizens of this state. Therefore, an emergency is declared to exist, and Sections 20 through 23 of this act, being immediately necessary for the preservation of the public peace, health, and safety, shall become effective on: (1) The date of this act’s approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2015, No. 871, § 35: Apr. 1, 2015. Emergency clause provided: “It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a one (1) year period; that the effectiveness of this Act on July 1, 2015 is essential to the operation of the agency for which the appropriations in this Act are provided; with the exception that SECTIONS 28, 31 and 32 in this Act shall be in full force and effect from and after the date of its passage and approval and SECTIONS 29 and 30 shall be in full force and effect from and after January 1, 2015, and that in the event of an extension of the Legislative Session, the delay in the effective date of this Act beyond July 1, 2015, with the exception that SECTIONS 28, 31 and 32 in this Act shall be in full force and effect from and after the date of its passage and approval and SECTIONS 29 and 30 shall be in full force and effect from and after January 1, 2015, could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2015; with the exceptions that SECTIONS 28, 31 and 32 in this Act shall be in full force and effect from and after the date of its passage and approval and SECTIONS 29 and 30 shall be in full force and effect from and after January 1, 2015.”

Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, § 8: Jan. 1, 2017. Effective date clause provided: “Section 3 and Section 4

of this act are effective on and after January 1, 2017.”

Identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 10: May 4, 2017. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act requires the transfer of oversight from the Arkansas Health Insurance Marketplace Legislative Oversight Committee to the Legislative Council and requires the Legislative Council to study various aspects of the Arkansas Health Insurance Marketplace; that the studies to be conducted by the Legislative Council are necessary to determine the future direction of the Arkansas Health Insurance Marketplace; and that this act is immediately necessary because the Legislative Council needs to be able to begin the oversight and study of the Arkansas Health Insurance Marketplace at the earliest possible date. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2019, No. 107, § 6: Mar. 15, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the citizens

of Arkansas would receive more benefits from the State Insurance Department operating the Arkansas Health Insurance Marketplace; that transfer of the operation of the Arkansas Health Insurance Marketplace impacts the expenses and operations of state government; and that this act is necessary to allow for the transition and implementation of the transfer before the upcoming fiscal year. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on March 15, 2019.”

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled ‘Funding and classification of cabinet-level department secretaries’ and ‘Transformation and Efficiencies Act transition team’ should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019.”

Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-801. Title.

This subchapter shall be known and may be cited as the “Arkansas Health Insurance Marketplace Act”.

History. Acts 2013, No. 1500, § 1.

23-61-802. Definitions.

As used in this subchapter:

(1) “Federal act” means the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to or regulations or guidance issued under those statutes existing on April 23, 2013;

(2)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(B) "Health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or both;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including without limitation general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013, under which benefits for healthcare services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or a combination of these; or

(iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013.

(D) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, Pub. L. No. 74-271, as existing on April 23, 2013;

(ii) Coverage supplemental to the coverage provided to military personnel and their dependents under Chapter 55 of Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services, 32 C.F.R. Part 199; or

(iii) Similar supplemental coverage provided to coverage under a group health plan;

(3) "Health insurance" means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining health insurance, but excluding:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Coverage only for limited scope vision benefits;

(I) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(J) Coverage for specified disease or critical illness;

(K) Hospital indemnity or other fixed indemnity insurance;

(L) Medicare supplement policies;

(M) Medicare, Medicaid, or the Federal Employees Health Benefits Program;

(N) Coverage only for medical and surgical outpatient benefits;

(O) Excess or stop-loss insurance; and

(P) Other similar insurance coverage:

(i) Under which benefits for health insurance are secondary or incidental to other insurance benefits; or

(ii) Specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013, under which benefits for healthcare services are secondary or incidental to other insurance benefits;

(4) "Health insurer" means an entity that provides health insurance or a health benefit plan in the State of Arkansas, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(5) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one (1) or more qualified health plans offered through the small business health options program, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(A) Has its principal place of business in this state and elects to provide coverage through the small business health options program to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the small business health options program to all of its eligible employees who are principally employed in this state;

(6) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act; and

(7)(A) "Small employer" means an employer that employed an average of not more than fifty (50) employees during the preceding calendar year.

(B) For purposes of this subdivision (7):

(i) All persons treated as a single employer under subsection (b), subsection (c), subsection (m), or subsection (o) of section 414 of the Internal Revenue Code of 1986 as existing on April 23, 2013, shall be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer;

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that the employer will employ on business days in the current calendar year; and

(v) An employer that makes enrollment in qualified health plans available to its employees through the small business health options program and would cease to be a small employer because of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this subchapter as long as it continuously makes enrollment through the small business health options program available to its employees.

History. Acts 2013, No. 1500, § 1.

U.S. Code. Section 1882(g)(1) of the Social Security Act, referred to in this section, is codified as 42 U.S.C. § 1395ss(g)(1).

Section 1311(c) of the federal act (Pub.

Law No. 111-148), referred to in this section, is codified as 42 U.S.C. § 18031(c).

Section 414 of the Internal Revenue Code of 1986, referred to in this section, is codified as 26 U.S.C. § 414.

23-61-803. Arkansas Health Insurance Marketplace. [Effective until January 1, 2022.]

(a) The Arkansas Health Insurance Marketplace is created as a division within the State Insurance Department.

(b) The State Insurance Department shall plan and administer the Arkansas Health Insurance Marketplace and employ necessary staff.

(c) The State Insurance Department shall keep an accurate accounting of all activities, receipts, and expenditures on behalf of the Arkansas Health Insurance Marketplace and report to the Legislative Council as requested by the Legislative Council.

(d) The State Insurance Department may apply for and expend on behalf of the Arkansas Health Insurance Marketplace any state,

federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace.

(e)(1) The State Insurance Department may contract with eligible entities to assist with the planning, implementation, and operation of the Arkansas Health Insurance Marketplace.

(2) For the purposes of this subsection:

(A) An eligible entity includes without limitation an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity; and

(B) A health insurer or an affiliate of a health insurer is not an eligible entity.

(3) In contracting with an eligible entity under subdivision (e)(1) of this section, the State Insurance Department shall give preference to eligible entities that have relevant experience.

(f) The State Insurance Department may enter into information-sharing agreements with federal and state agencies and other state marketplaces to carry out its responsibilities under this subchapter, provided such agreements:

(1) Include adequate protections with respect to the confidentiality of the information to be shared; and

(2) Comply with all applicable state and federal laws and regulations.

(g) As a condition of participating in the Arkansas Health Insurance Marketplace, a health insurer shall pay the assessments, submit the reports, and provide the information required by the Insurance Commissioner to implement this subchapter.

(h) The State Insurance Department and any eligible entity under subdivision (e)(1) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the Arkansas Works Program established by the Arkansas Works Act of 2016, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

(i)(1) The Legislative Council may study matters pertaining to this subchapter that the Legislative Council considers necessary to fulfill its mandate under this subchapter.

(2) The Legislative Council may request reports from the Arkansas Health Insurance Marketplace pertaining to the operations, programs, or finances of the Arkansas Health Insurance Marketplace as it deems necessary.

(3) Annually by December 15, the Legislative Council shall provide to the General Assembly any analysis or findings resulting from its activities under this section that the Legislative Council deems relevant.

(4)(A) During a regular, fiscal, or extraordinary session of the General Assembly, the Joint Budget Committee shall perform the functions assigned to the Legislative Council under this subchapter.

(B) This subsection does not limit the authority of the Legislative Council and its subcommittees to meet during a recess as authorized by § 10-2-223 or § 10-3-211.

(5) The Legislative Council and the Joint Budget Committee may:

(A) Establish or utilize one (1) or more subcommittees to assist in the duties of the Legislative Council or the Joint Budget Committee, respectively, under this subchapter;

(B) Assign information filed with the Legislative Council under this subchapter to one (1) or more subcommittees of the Legislative Council or the Joint Budget Committee, respectively, including without limitation a subcommittee created under subdivision (i)(5)(A) of this section; and

(C) Delegate the duties of the Legislative Council or the Joint Budget Committee, respectively, under this subchapter to one (1) or more subcommittees of the Legislative Council or the Joint Budget Committee, respectively, subject to the final review and approval of the Legislative Council or the Joint Budget Committee, respectively.

History. Acts 2013, No. 1500, § 1; 2014, No. 282, § 23; 2015, No. 1100, § 57; 2017 (1st Ex. Sess.), No. 4, § 5; 2017 (1st Ex. Sess.), No. 5, § 5; 2019, No. 107, § 2; 2019, No. 910, § 5240.

A.C.R.C. Notes. In reference to the term, “if enacted”, the Health Care Independence Act of 2013, § 20-77-2401 et seq., was enacted by Acts 2013, No. 1498, effective April 23, 2013.

Identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 1, provided: “Legislative findings and intent.

“(a) The General Assembly finds that:

“(1) Since the enactment of Acts 2013, No. 1500, several changes regarding the health insurance marketplaces have occurred on a federal level that have modified the operation of the health insurance marketplaces;

“(2) The federal government is expected to propose additional changes regarding the health insurance marketplaces in the next year; and

“(3) Due to the ongoing changes at the federal level regarding health insurance, prohibiting development of technology for a state-based platform for the individual health insurance marketplace and reviewing the direction of the Arkansas Health Insurance Marketplace would be beneficial to the State of Arkansas for the future efficiency, sustainability, and transpar-

ency of the Arkansas Health Insurance Marketplace.

“(b) It is the intent of the General Assembly through this act to:

“(1) Prohibit development of technology for a state-based platform for the individual health insurance marketplace;

“(2) Impose certain reporting requirements on the Arkansas Health Insurance Marketplace to ensure that the Governor and the General Assembly are better informed about the Arkansas Health Insurance Marketplace; and

“(3) Transfer oversight of the Arkansas Health Insurance Marketplace from the Arkansas Health Insurance Marketplace Legislative Oversight Committee to the Legislative Council.”

Publisher’s Notes. For text of section effective January 1, 2022, see the following version.

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 4 and 5 deleted (b)(3)(A)(iii) and added (q); substituted “Legislative Council” for “Arkansas Health Insurance Marketplace Legislative Oversight Committee” in (b)(3)(D)(i), (b)(3)(F), (g)(1), (j)(2), twice in (k), and (m)(4)(B); substituted “Arkansas Health Insurance Marketplace” for “Legislative Council” in (b)(3)(F); deleted “within ninety (90) days after the appointment of the board” from the end of (j)(1); substi-

tuted "Arkansas Works Program established by the Arkansas Works Act of 2016, § 23-61-1001 et seq." for "Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted" in (p)(2); and made stylistic changes.

The 2019 amendment by No. 107 rewrote the section.

The 2019 amendment by No. 910 substituted "Secretary of the Department of Human Services" for "Director of the Department of Human Services" in (c)(5).

23-61-803. Arkansas Health Insurance Marketplace. [Effective January 1, 2022.]

(a) The Arkansas Health Insurance Marketplace is created as a division within the State Insurance Department.

(b) The State Insurance Department shall plan and administer the Arkansas Health Insurance Marketplace and employ necessary staff.

(c) The State Insurance Department shall keep an accurate accounting of all activities, receipts, and expenditures on behalf of the Arkansas Health Insurance Marketplace and report to the Legislative Council as requested by the Legislative Council.

(d) The State Insurance Department may apply for and expend on behalf of the Arkansas Health Insurance Marketplace any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace.

(e)(1) The State Insurance Department may contract with eligible entities to assist with the planning, implementation, and operation of the Arkansas Health Insurance Marketplace.

(2) For the purposes of this subsection:

(A) An eligible entity includes without limitation an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity; and

(B) A health insurer or an affiliate of a health insurer is not an eligible entity.

(3) In contracting with an eligible entity under subdivision (e)(1) of this section, the State Insurance Department shall give preference to eligible entities that have relevant experience.

(f) The State Insurance Department may enter into information-sharing agreements with federal and state agencies and other state marketplaces to carry out its responsibilities under this subchapter, provided such agreements:

(1) Include adequate protections with respect to the confidentiality of the information to be shared; and

(2) Comply with all applicable state and federal laws and regulations.

(g) As a condition of participating in the Arkansas Health Insurance Marketplace, a health insurer shall pay the assessments, submit the reports, and provide the information required by the Insurance Commissioner to implement this subchapter.

(h) The State Insurance Department and any eligible entity under subdivision (e)(2) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the Arkansas Health and Opportunity for Me Program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

(i)(1) The Legislative Council may study matters pertaining to this subchapter that the Legislative Council considers necessary to fulfill its mandate under this subchapter.

(2) The Legislative Council may request reports from the Arkansas Health Insurance Marketplace pertaining to the operations, programs, or finances of the Arkansas Health Insurance Marketplace as it deems necessary.

(3) Annually by December 15, the Legislative Council shall provide to the General Assembly any analysis or findings resulting from its activities under this section that the Legislative Council deems relevant.

(4)(A) During a regular, fiscal, or extraordinary session of the General Assembly, the Joint Budget Committee shall perform the functions assigned to the Legislative Council under this subchapter.

(B) This subsection does not limit the authority of the Legislative Council and its subcommittees to meet during a recess as authorized by § 10-2-223 or § 10-3-211.

(5) The Legislative Council and the Joint Budget Committee may:

(A) Establish or utilize one (1) or more subcommittees to assist in the duties of the Legislative Council or the Joint Budget Committee, respectively, under this subchapter;

(B) Assign information filed with the Legislative Council under this subchapter to one (1) or more subcommittees of the Legislative Council or the Joint Budget Committee, respectively, including without limitation a subcommittee created under subdivision (i)(5)(A) of this section; and

(C) Delegate the duties of the Legislative Council or the Joint Budget Committee, respectively, under this subchapter to one (1) or more subcommittees of the Legislative Council or the Joint Budget Committee, respectively, subject to the final review and approval of the Legislative Council or the Joint Budget Committee, respectively.

History. Acts 2013, No. 1500, § 1; 2014, No. 282, § 23; 2015, No. 1100, § 57; 2017 (1st Ex. Sess.), No. 4, § 5; 2017 (1st Ex. Sess.), No. 5, § 5; 2019, No. 107, § 2; 2019, No. 910, § 5240; 2021, No. 530, § 4.

A.C.R.C. Notes. In reference to the term, "if enacted", the Health Care Independence Act of 2013, § 20-77-2401 et seq., was enacted by Acts 2013, No. 1498,

effective April 23, 2013.

Identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) Since the enactment of Acts 2013, No. 1500, several changes regarding the health insurance marketplaces have occurred on a federal level that have modi-

fied the operation of the health insurance marketplaces;

“(2) The federal government is expected to propose additional changes regarding the health insurance marketplaces in the next year; and

“(3) Due to the ongoing changes at the federal level regarding health insurance, prohibiting development of technology for a state-based platform for the individual health insurance marketplace and reviewing the direction of the Arkansas Health Insurance Marketplace would be beneficial to the State of Arkansas for the future efficiency, sustainability, and transparency of the Arkansas Health Insurance Marketplace.

“(b) It is the intent of the General Assembly through this act to:

“(1) Prohibit development of technology for a state-based platform for the individual health insurance marketplace;

“(2) Impose certain reporting requirements on the Arkansas Health Insurance Marketplace to ensure that the Governor and the General Assembly are better informed about the Arkansas Health Insurance Marketplace; and

“(3) Transfer oversight of the Arkansas Health Insurance Marketplace from the Arkansas Health Insurance Marketplace Legislative Oversight Committee to the Legislative Council.”

Publisher’s Notes. For text of section effective until January 1, 2022, see the preceding version.

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 4 and 5 deleted (b)(3)(A)(iii) and added (q); substituted “Legislative Council” for “Arkansas Health Insurance Marketplace Legislative Oversight Committee” in (b)(3)(D)(i), (b)(3)(F), (g)(1), (j)(2), twice in (k), and (m)(4)(B); substituted “Arkansas Health Insurance Marketplace” for “Legislative Council” in (b)(3)(F); deleted “within ninety (90) days after the appointment of the board” from the end of (j)(1); substituted “Arkansas Works Program established by the Arkansas Works Act of 2016, § 23-61-1001 et seq.” for “Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted” in (p)(2); and made stylistic changes.

The 2019 amendment by No. 107 rewrote the section.

The 2019 amendment by No. 910 substituted “Secretary of the Department of Human Services” for “Director of the Department of Human Services” in (c)(5).

The 2021 amendment substituted “subdivision (e)(2)” for “subdivision (e)(1)” in the introductory language of (h); and, in (h)(2), substituted “Arkansas Health and Opportunity for Me Program” for “Arkansas Works Program” and “Arkansas Health and Opportunity for Me Act of 2021” for “Arkansas Works Act of 2016”.

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-804. Duties of Arkansas Health Insurance Marketplace.

(a) The Arkansas Health Insurance Marketplace shall:

(1) Implement procedures and criteria for the certification, recertification, and decertification of health benefit plans as qualified health plans in compliance with state and federal law;

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) Require that a health carrier offering a qualified health plan post on the public part of its website in a readily accessible format the formulary list for each individual qualified health plan and the following information:

(A) The qualified health plan to which the formulary applies;

(B) Any exclusions from coverage or restrictions, including:

(i) Any tiering structure, including copay and coinsurance requirements;

(ii) Prior authorization requirements;

(iii) [Repealed.]

(iv) Deductibles and cost sharing;

(v) Quantity limits; and

(vi) Whether access is dependent upon the location where a prescription drug is obtained or administered; and

(C) The appeal process for a denial of coverage or adverse determination for an item or service for a prescription drug;

(4)(A) Establish a small business health options program through which qualified employers may access coverage for their employees.

(B) The small business health options program, without limitation, shall enable a qualified employer to specify a level of coverage so that any of its employees may enroll in a qualified health plan offered through the program at the specified level of coverage.

(C) This subdivision (a)(4) does not apply if an available qualified health carrier does not offer a health benefit plan under the small business health options program;

(5)(A) Select entities qualified to serve as navigators and award grants to enable navigators to:

(i) Conduct public education activities to raise awareness of the availability of qualified health plans;

(ii) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under 26 U.S.C. § 36B, as existing on April 23, 2013, and cost-sharing reductions under section 1402 of the federal act;

(iii) Facilitate enrollment in qualified health plans;

(iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or to any other appropriate state agency for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan or health benefit coverage or a determination under his or her health benefit plan or health benefit coverage; and

(v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Arkansas Health Insurance Marketplace.

(B) The Insurance Commissioner shall ensure in the navigator selection process that the navigators are geographically, culturally, ethnically, and racially representative of the populations served; and

(6) Otherwise comply with a requirement the commissioner determines is necessary to obtain or maintain the approval to administer a health insurance marketplace.

(b) If the Governor determines that a state-based exchange not on the federal platform for the individual health insurance marketplace is beneficial and appropriate, the Arkansas Health Insurance Marketplace shall:

(1)(A) Maintain a website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.

(B) The commissioner shall ensure that an entity offering a qualified health plan through the Arkansas Health Insurance Mar-

ketplace posts the information described in § 23-79-159 on the Arkansas Health Insurance Marketplace website in a readily accessible format;

(2) Assign a rating to each qualified health plan offered through the Arkansas Health Insurance Marketplace and determine each qualified health plan's level of coverage in accordance with regulations issued by the United States Secretary of Health and Human Services under section 1302(d)(2)(A) of the federal act;

(3) Use a standardized format for presenting health benefit options in the Arkansas Health Insurance Marketplace; and

(4) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of a premium tax credit under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, and any cost-sharing reduction under section 1402 of the federal act.

History. Acts 2013, No. 1500, § 1; 2015, No. 1109, § 1; 2017 (1st Ex. Sess.), No. 4, §§ 6, 7; 2017 (1st Ex. Sess.), No. 5, §§ 6, 7; 2019, No. 107, § 3; 2021, No. 97, § 1.

A.C.R.C. Notes. In reference to the term, "if enacted", the Health Care Independence Act of 2013, § 20-77-2401 et seq., was enacted by Acts 2013, No. 1498, effective April 23, 2013.

Identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) Since the enactment of Acts 2013, No. 1500, several changes regarding the health insurance marketplaces have occurred on a federal level that have modified the operation of the health insurance marketplaces;

"(2) The federal government is expected to propose additional changes regarding the health insurance marketplaces in the next year; and

"(3) Due to the ongoing changes at the federal level regarding health insurance, prohibiting development of technology for a state-based platform for the individual health insurance marketplace and reviewing the direction of the Arkansas Health Insurance Marketplace would be beneficial to the State of Arkansas for the future efficiency, sustainability, and transparency of the Arkansas Health Insurance Marketplace.

"(b) It is the intent of the General As-

sembly through this act to:

"(1) Prohibit development of technology for a state-based platform for the individual health insurance marketplace;

"(2) Impose certain reporting requirements on the Arkansas Health Insurance Marketplace to ensure that the Governor and the General Assembly are better informed about the Arkansas Health Insurance Marketplace; and

"(3) Transfer oversight of the Arkansas Health Insurance Marketplace from the Arkansas Health Insurance Marketplace Legislative Oversight Committee to the Legislative Council."

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 4 and 5 substituted "Arkansas Works Program established by the Arkansas Works Act of 2016, § 23-61-1001 et seq." for "Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted" in (1)(B)(ii) and (iii); and substituted "administer a" for "establish or administer a state-based" in (13).

The 2019 amendment rewrote the section.

The 2021 amendment repealed (a)(3)(B)(iii).

U.S. Code. Section 1402 of the federal act (Pub. Law No. 111-148), referred to in this section, is codified as 42 U.S.C. § 18071. Section 1302(d)(2)(A) of the federal act is codified as 42 U.S.C. § 18022(d)(2)(A).

23-61-805. Funding — Publication of costs.

(a)(1) The General Assembly shall establish a reasonable initial assessment or user fee and reasonable increases or decreases in the amount of future assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers for the efficient operation of the Arkansas Health Insurance Marketplace.

(2) Annually by October 1, the State Insurance Department shall report to the Legislative Council in the manner and format that the Legislative Council requires the recommendations of the department for the initial assessment or user fee and increases or decreases in the amount of future assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers.

(3) Annually by December 1, the Legislative Council shall review the recommendations of the department under subdivision (a)(2) of this section and report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives the recommendations of the Legislative Council for the initial assessment or user fee and future increases or decreases in the amount of assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers.

(b)(1) All assessments and fees shall be due and payable upon receipt in the matter required by the Insurance Commissioner and shall be delinquent if not paid within thirty (30) days of the receipt of notice of the assessment by the health insurer.

(2)(A) Failure to timely pay the assessment shall automatically subject the health insurer to a penalty not to exceed ten percent (10%) of the assessment plus interest as established under subsection (a) of this section.

(B) The penalty and interest is due and payable within the next thirty-day period.

(3) The commissioner may enforce the collection of the assessment and penalty and interest in accordance with this subchapter and the Arkansas Insurance Code.

(4) The commissioner may waive the penalty and interest authorized by this subsection if the commissioner determines that compelling circumstances exist that justify a waiver.

(c)(1) The department shall publish the average costs of licensing, regulatory fees, and any other payments required by the Arkansas Health Insurance Marketplace and the administrative costs of the Arkansas Health Insurance Marketplace on an internet website to educate consumers on such costs.

(2) Information published under subdivision (c)(1) of this section shall include information on moneys lost to waste, fraud, and abuse.

History. Acts 2013, No. 1500, § 1; 2016 (2nd Ex. Sess.), No. 1, § 3; 2016 (2nd Ex. Sess.), No. 2, § 3; 2017 (1st Ex. Sess.), No. 4, §§ 8, 9; 2017 (1st Ex. Sess.), No. 5, §§ 8, 9; 2019, No. 107, § 4; 2019, No. 391, § 6.

A.C.R.C. Notes. Identical Acts 2017 (1st Ex. Sess.), Nos. 4 and 5, § 1, provided: “Legislative findings and intent.

“(a) The General Assembly finds that:

“(1) Since the enactment of Acts 2013, No. 1500, several changes regarding the health insurance marketplaces have occurred on a federal level that have modified the operation of the health insurance marketplaces;

“(2) The federal government is expected to propose additional changes regarding the health insurance marketplaces in the next year; and

“(3) Due to the ongoing changes at the federal level regarding health insurance, prohibiting development of technology for a state-based platform for the individual health insurance marketplace and reviewing the direction of the Arkansas Health Insurance Marketplace would be beneficial to the State of Arkansas for the future efficiency, sustainability, and transparency of the Arkansas Health Insurance Marketplace.

“(b) It is the intent of the General Assembly through this act to:

“(1) Prohibit development of technology for a state-based platform for the individual health insurance marketplace;

“(2) Impose certain reporting requirements on the Arkansas Health Insurance Marketplace to ensure that the Governor and the General Assembly are better informed about the Arkansas Health Insurance Marketplace; and

“(3) Transfer oversight of the Arkansas Health Insurance Marketplace from the Arkansas Health Insurance Marketplace Legislative Oversight Committee to the Legislative Council.”

Publisher’s Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-60-101.

Amendments. The 2016 (2nd Ex.

Sess.) amendment by identical acts Nos. 1 and 2 repealed (b).

The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 4 and 5 substituted “Legislative Council” for “Arkansas Health Insurance Marketplace Legislative Oversight Committee” in (a)(2) twice and in (a)(3); in (a)(2), substituted “Annually by October 1” for “Beginning October 1, 2014, and annually by October 1 thereafter” and substituted “recommendations of the Arkansas Health Insurance Marketplace” for “Arkansas Health Insurance Marketplace’s recommendations”; in (a)(3), substituted “Annually by December 1” for “Beginning January 1, 2015, and annually by January 1 thereafter” and “recommendations of the Legislative Council” for “Arkansas Health Insurance Marketplace Legislative Oversight Committee’s recommendations”; and added (e).

The 2019 amendment by No. 107 substituted “State Insurance Department” for “Arkansas Health Insurance Marketplace” in (a)(2) and “department” for “Arkansas Health Insurance Marketplace” in (a)(2), (a)(3), and (c)(1); deleted former (b) “[Repealed.]”; redesignated former (c) and (d) as (b) and (c); inserted “in the matter required by the Insurance Commissioner” in (b)(1); substituted “commissioner” for “Board of Directors of the Arkansas Health Insurance Marketplace and the Insurance Commissioner” in (b)(3); substituted “commissioner” for “board” twice in (b)(4); substituted “subdivision (c)(1)” for “subdivision (d)(1)” in subdivision (c)(2); and deleted former (e), concerning annual reporting by the Arkansas Health Insurance Marketplace.

The 2019 amendment by No. 391 substituted “subdivision (a)(2) of this section” for “subdivision (a)(1) of this section” in (a)(3); deleted (b), which had been previously repealed; redesignated former (c)(1) as (b)(1) and redesignated the remaining subdivisions accordingly; and substituted “subdivision (c)(1) of this section” for “subdivision (d)(1) of this section” in (c)(2).

Effective Dates. Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, § 8; Jan. 1, 2017. Effective date clause provided: “Section 3 and Section 4 of this act are effective on and after January 1, 2017.”

23-61-806. Rules.

(a) The Insurance Commissioner may promulgate rules to implement this subchapter.

(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the United States Secretary of Health and Human Services under the federal act.

History. Acts 2013, No. 1500, § 1.

23-61-807. Relation to other laws.

(a) This subchapter is amendatory to the Arkansas Insurance Code.

(b) Provisions of the Arkansas Insurance Code that are not in conflict with this subchapter are applicable to this subchapter.

(c) This subchapter and actions taken by the Arkansas Health Insurance Marketplace under this subchapter shall not be construed to preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.

(d) Except as expressly provided to the contrary in this subchapter, a health insurer offering a qualified health plan in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

History. Acts 2013, No. 1500, § 1; 2019, No. 315, § 2624.

Publisher's Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No.

148. Acts 1959, No. 148, is codified as set out in the note following § 23-60-101.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (d).

23-61-808. [Repealed.]

Publisher's Notes. This section, concerning the restriction on use of grant funds for final implementation of the state-based health insurance exchange,

was repealed by Acts 2019, No. 107, § 5, effective March 15, 2019. The section was derived from Acts 2015, No. 871, § 32.

SUBCHAPTER 9 — ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE ACT OF 2015

SECTION.

23-61-901. Title.

23-61-902. Legislative intent and purpose.

23-61-903. Definitions.

23-61-904. Arkansas Healthcare Transparency Initiative.

23-61-905. Arkansas Healthcare Transparency Initiative Board — Membership — Duties.

23-61-906. Data submission.

SECTION.

23-61-907. Data release.

23-61-908. Penalties for failure to submit data.

23-61-909. Data collected under State Health Data Clearinghouse Act.

23-61-910. Data collected regarding hospital discharge and emergency department records.

Preambles. Acts 2015, No. 1233, contained a preamble which read:

“WHEREAS, Arkansans face a challenge finding reliable, consumer-friendly information on healthcare utilization, quality, and pricing; and

“WHEREAS, greater transparency of healthcare utilization, quality, and price information leads to more informed, engaged, activated consumers; and

“WHEREAS, Arkansas has taken significant steps to advance system-wide payment reform, and optimizing the state’s efforts requires transforming our healthcare system into a more transparent, more informed, consumer-driven enterprise; and

“WHEREAS, the Arkansas Health Care Reform Act of 2015 creates a task force to assess cost-effective opportunities to provide coverage to Health Care Independence Program participants upon its termination, as well as opportunities to reform the Arkansas Medicaid Program and create a more transparent healthcare system; and

“WHEREAS, information about healthcare utilization, quality, and pricing allows policymakers to evaluate health programs and monitor the success and efficiency of efforts to enhance access, reduce healthcare costs, and improve both healthcare quality and population health; and

“WHEREAS, the availability and integration of healthcare information for legitimate research purposes to qualified researchers supports the pursuits of the state’s academic institutions and the continued study of the evolving landscape of the state’s health and healthcare system; and

“WHEREAS, comparative healthcare information supports efforts to design targeted quality-improvement initiatives and to compare provider performance with that of other provider peers; and

“WHEREAS, other states have learned the value of integrating healthcare data and transforming it into useful information to the benefit of their citizens while protecting the privacy rights of all individuals; and

“WHEREAS, demands for information to support program evaluation and healthcare reform and its impact on con-

sumers, businesses, and the state constitute an emergency; and

“WHEREAS, the General Assembly hereby creates the Arkansas Healthcare Transparency Initiative,

“NOW THEREFORE, ...”

Effective Dates. Acts 2015, No. 1233, § 3: Apr. 7, 2015. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that there is a lack of available information to support the required evaluation of state programs and the deliberations of policymakers within the timeframe required by the Health Care Reform Act of 2015, and that there is an immediate need to collect data to support these activities so that policymakers may make more informed decisions about the cost-effectiveness of current programs and the future of the state’s healthcare system. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled ‘Funding and classification of cabinet-level department secretaries’ and ‘Transformation and Efficiencies Act transition team’ should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019.”

23-61-901. Title.

This subchapter shall be known and may be cited as the “Arkansas Healthcare Transparency Initiative Act of 2015”.

History. Acts 2015, No. 1233, § 1.

23-61-902. Legislative intent and purpose.

(a) It is the intent of the General Assembly to create and maintain an informative source of healthcare information to support consumers, researchers, and policymakers in healthcare decisions within the state, including decisions by the State Insurance Department to regulate the business of insurance in this state.

(b) The purpose of this subchapter is to:

(1) Empower Arkansans to drive, deliver, and seek out value in the healthcare system;

(2) Create the Arkansas Healthcare Transparency Initiative;

(3) Establish governance of the Arkansas Healthcare Transparency Initiative;

(4) Provide authority to collect healthcare information from insurance carriers and other entities; and

(5) Establish appropriate methods for collecting, maintaining, and reporting healthcare information, including privacy and security safeguards.

History. Acts 2015, No. 1233, § 1; added “including decisions by the State Insurance Department to regulate the business of insurance in this state” in (a).
2017, No. 979, § 2.

Amendments. The 2017 amendment

23-61-903. Definitions.

As used in this subchapter:

(1) “Arkansas Healthcare Transparency Initiative” means an initiative to create a database, including ongoing all-payer claims database projects funded through the State Insurance Department, that receives and stores data from a submitting entity relating to medical, dental, and pharmaceutical and other insurance claims information, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter, and provider files, for the purposes of this subchapter;

(2) “Arkansas resident” means an individual for whom the submitting entity has identified an Arkansas address as the individual’s primary place of residence;

(3) “Claims data” means information included in an institutional, professional, or pharmacy claim or equivalent information transaction for a covered individual, including the amount paid to a provider of healthcare services plus any amount owed by the covered individual;

(4) “Covered individual” means a natural person who is an Arkansas resident and is eligible to receive medical, dental, or pharmaceutical

benefits under any policy, contract, certificate, evidence of coverage, rider, binder, or endorsement that provides for or describes coverage;

(5)(A) "Direct personal identifiers" means information relating to a covered individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(B) "Direct personal identifiers" does not include geographic or demographic information that would not allow the identification of a covered individual;

(6) "Enrollment data" means demographic information and other identifying information relating to covered individuals, including direct personal identifiers;

(7) "Protected health information" means health information as protected by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as it existed on January 1, 2015;

(8) "Provider" means an individual or entity licensed by the state to provide healthcare services;

(9)(A) "Submitting entity" means:

(i) An entity that provides health or dental insurance or a health or dental benefit plan in the state, including without limitation an insurance company, medical services plan, managed care organization, hospital plan, hospital medical service corporation, health maintenance organization, or fraternal benefit society, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals in the previous calendar year;

(ii) A health benefit plan offered or administered by or on behalf of the state or an agency or instrumentality of the state, including without limitation benefits administered by a managed care organization whether or not the managed care organization had two thousand (2,000) covered individuals in the previous year;

(iii) A health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government;

(iv) The Workers' Compensation Commission;

(v) Any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, a third-party administrator, or a pharmacy benefits manager, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals in the previous calendar year;

(vi) A health benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, and that is fully insured;

(vii) A risk-based provider organization licensed by the State Insurance Department; and

(viii) An entity that contracts with institutions of the Division of Correction or the Division of Community Correction to provide medical, dental, or pharmaceutical care to inmates.

(B) "Submitting entity" does not include:

(i) An entity that provides health insurance or a health benefit plan that is accident-only, specified disease, hospital indemnity, long-term care, disability income, or other supplemental benefit coverage;

(ii) An employee of a welfare benefit plan as defined by federal law that is also a trust established pursuant to collective bargaining subject to the Labor Management Relations Act, 1947, Pub. L. No. 80-101; or

(iii) A health benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, that is self-funded; and

(10) “Unique identifier” means any identifier that is guaranteed to be unique among all identifiers for covered individuals but does not include direct personal identifiers.

History. Acts 2015, No. 1233, § 1; 2017, No. 979, § 3; 2019, No. 910, § 1017.

Amendments. The 2017 amendment inserted “managed care organization” in (9)(A)(i); inserted “including without limitation benefits administered by a managed care organization whether or not the managed care organization had two thousand (2,000) covered individuals in the previous year” in (9)(A)(ii); substituted “and that is fully insured” for “as permitted by federal law, provided that the health benefit plan does not include an

employee welfare benefit plan, as defined by federal law, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the Labor Management Relations Act of 1947, 29 U.S.C. §§ 401 — 531” in (9)(A)(vi); and added (9)(A)(vii), (9)(B)(ii) and (B)(iii).

The 2019 amendment, in (9)(A)(viii), substituted “Division of Correction” for “Department of Correction” and “Division of Community Correction” for “Department of Community Correction”.

23-61-904. Arkansas Healthcare Transparency Initiative.

(a) The Arkansas Healthcare Transparency Initiative is established with the purpose to create a database, including ongoing all-payer claims database projects funded through the State Insurance Department, that receives and stores data from a submitting entity relating to medical, dental, and pharmaceutical and other insurance claims information, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter, and provider files, for the purposes of this subchapter.

(b) The Arkansas Healthcare Transparency Initiative shall be governed by the department and advised by the Arkansas Healthcare Transparency Initiative Board.

History. Acts 2015, No. 1233, § 1.

23-61-905. Arkansas Healthcare Transparency Initiative Board — Membership — Duties.

(a)(1) There is created the Arkansas Healthcare Transparency Initiative Board, which shall be composed of the following members:

(A) A representative of the Department of Human Services;

(B) A representative of the Department of Health;

(C) A representative of the Office of Health Information Technology or its successor entity as provided by state law;

(D) The Arkansas Surgeon General;

(E) Nine (9) members appointed by the Governor as follows:

(i) Two (2) representatives from the health insurance industry, one (1) of whom shall be a multistate representative and one (1) of whom shall be a domestic representative;

(ii) Two (2) representatives from the healthcare provider community;

(iii) A representative from a self-insured employer;

(iv) A representative from an employer of fewer than one hundred (100) full-time employees that provides healthcare coverage to employees through a fully-insured product;

(v) A representative from a healthcare consumer organization;

(vi) A representative from the academic research community with expertise in healthcare claims data analysis; and

(vii) A representative with expertise in health data privacy and security; and

(F) A representative from the Arkansas Biosciences Institute who shall serve as an ex-officio, nonvoting member.

(2) A Governor-appointed member of the board in subdivision (a)(1)(E) of this section shall serve for a term of three (3) years.

(3) The board shall appoint one (1) member as Chair of the Arkansas Healthcare Transparency Initiative Board and determine the qualifications, duties, and the term of office of the chair.

(4) Seven (7) members present constitute a quorum.

(5) The board shall hold its first meeting no later than July 1, 2015.

(b) The State Insurance Department shall:

(1) Have the authority to:

(A) Collect, validate, analyze, and present health data, including claims data;

(B) Assess penalties for noncompliance with this subchapter; and

(C) Establish and convene additional subcommittees to carry out the purposes of this subchapter;

(2) Designate the Arkansas Center for Health Improvement as the Administrator of the Arkansas Healthcare Transparency Initiative, which shall be responsible for development and implementation of a sustainability plan subject to data use and disclosure requirements of this subchapter and any rules promulgated under this subchapter;

(3) With the assistance of the Administrator of the Arkansas Healthcare Transparency Initiative, establish and convene the following subcommittees:

(A) The Data Oversight Subcommittee of the Arkansas Healthcare Transparency Initiative, which shall:

(i) Consist of:

(a) Three (3) Governor-appointed board members; and

(b) One (1) individual healthcare consumer; and

(ii) Review and make recommendations to the State Insurance Department regarding:

(a) Data requests for consistency with the intent and purpose of this subchapter, including whether the data request contains the minimum required information; and

(b) Reports and publications generated from data requests to ensure compliance with this subchapter; and

(B) The Scientific Advisory Subcommittee of the Arkansas Healthcare Transparency Initiative, which shall:

(i) Consist of:

(a) The Governor-appointed member of the board from the academic research community; and

(b) Two (2) nonmembers of the board who are academic researchers; and

(ii) Serve as peer review for academic researchers and provide advice regarding data requests for academic proposals and the scientific rigor of analytic work; and

(4) Adopt any rules necessary to implement this subchapter under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(c) In consultation with the board, the State Insurance Department shall exercise its powers and duties under this subchapter to:

(1) Establish policies and procedures necessary for the administration and oversight of the Arkansas Healthcare Transparency Initiative, including procedures for the collection, processing, storage, analysis, use, and release of data;

(2) Identify and explore the key healthcare issues, questions, and problems that may be improved through more transparent information, including without limitation data required to be disclosed to patients related to provider relationships or affiliations with payers and providers, financial interests in healthcare businesses, and payments or items of any value given to providers from pharmaceutical or medical device manufacturers or agents thereof; and

(3) Provide a biennial report to the General Assembly on the operations of the Arkansas Healthcare Transparency Initiative.

History. Acts 2015, No. 1233, § 1; **Amendments.** The 2017 amendment 2017, No. 979, § 4. added (a)(1)(F).

23-61-906. Data submission.

(a) Except as provided in subsection (d) of this section, no later than January 1, 2016, and every quarter thereafter, a submitting entity shall submit health and dental claims data, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter, and provider files to the Arkansas Healthcare Transparency Initiative in accordance with standards and procedures adopted by the State Insurance Department.

(b) Data submitted under this subchapter shall be treated as confidential and are exempt from disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., and are not subject to subpoena, except to the extent provided in § 23-61-205.

(c) The collection, storage, and release of data and other information under this section is subject to applicable state and federal data privacy and security law.

(d) No later than July 1, 2015, a submitting entity shall submit health and dental claims data, unique identifiers, and geographic and demographic information for covered individuals as permitted in this subchapter to the Arkansas Healthcare Transparency Initiative to support deliberations of the Arkansas Health Reform Legislative Task Force.

History. Acts 2015, No. 1233, § 1.

23-61-907. Data release.

(a) Data in the Arkansas Healthcare Transparency Initiative shall:

(1) To the extent authorized by the State Insurance Department, be available:

(A) When disclosed in a form and manner that ensures the privacy and security of protected health information as required by state and federal laws, as a resource to insurers, employers, purchasers of health care, researchers, state agencies, and healthcare providers to allow for assessment of healthcare utilization, expenditures, and performance in this state, including without limitation as a resource for hospital community health needs assessments; and

(B) To state programs regarding healthcare quality and costs for use in improving health care in the state, subject to rules prescribed by the department conforming to state and federal privacy laws or limiting access to limited-use data sets; and

(2) Not be used to:

(A) Disclose trade secrets of submitting entities;

(B) Reidentify or attempt to reidentify an individual who is the subject of any submitted data without obtaining the individual's consent; or

(C) Create or augment data contained in a national claims database.

(b) Notwithstanding the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, or any other provision of law, the Arkansas Healthcare Transparency Initiative shall not publicly disclose any data that contains direct personal identifiers.

History. Acts 2015, No. 1233, § 1.

23-61-908. Penalties for failure to submit data.

(a) Except for state or federal agencies that are submitting entities, a submitting entity that fails to submit data as required by this subchapter or the rules of the State Insurance Department may be subject to a penalty.

(b) The department shall adopt a schedule of penalties not to exceed one thousand dollars (\$1,000) per day of violation, determined by the severity of the violation.

(c) A penalty imposed under this section may be remitted or mitigated upon such terms and conditions as the department considers proper and consistent with the public health and safety.

(d) A penalty remitted under this section shall be used for Arkansas Healthcare Transparency Initiative operations.

History. Acts 2015, No. 1233, § 1.

23-61-909. Data collected under State Health Data Clearinghouse Act.

(a) The Department of Health shall submit data collected under the State Health Data Clearinghouse Act, § 20-7-301 et seq., to the Arkansas Healthcare Transparency Initiative for integration into the Arkansas Healthcare Transparency Initiative database created under § 23-61-904.

(b) The data submitted under subsection (a) of this section:

(1) Shall be assigned a unique identifier as defined in § 23-61-903; and

(2) May be used in accordance with the purposes of the Arkansas Healthcare Transparency Initiative and the rules promulgated under this subchapter.

History. Acts 2017, No. 979, § 5.

23-61-910. Data collected regarding hospital discharge and emergency department records.

(a) The Department of Health shall submit data collected regarding hospital discharge and emergency department records for the uninsured, birth and death records, and disease registry data under the State Health Data Clearinghouse Act, § 20-7-301 et seq., § 20-15-201 et seq., and § 20-18-201, to the Arkansas Healthcare Transparency Initiative Board for integration into the Arkansas Healthcare Transparency Initiative database created under § 23-61-904.

(b) The data submitted under subsection (a) of this section:

(1) Shall be assigned a unique identifier as defined in § 23-61-903; and

(2) May be used in accordance with the purposes of the Arkansas Healthcare Transparency Initiative and the rules promulgated under this subchapter.

History. Acts 2017, No. 979, § 5.

SUBCHAPTER 10 — ARKANSAS WORKS ACT OF 2016 [EFFECTIVE UNTIL JANUARY 1, 2022]

SECTION.

- 23-61-1001. Title. [Effective until January 1, 2022.]
- 23-61-1002. Legislative intent. [Effective until January 1, 2022.]
- 23-61-1003. Definitions. [Effective until January 1, 2022.]
- 23-61-1004. Administration of Arkansas Works Program. [Effective until January 1, 2022.]
- 23-61-1005. Requirements for eligible individuals. [Effective until January 1, 2022.]

SECTION.

- 23-61-1006. Requirements for program participants. [Effective until January 1, 2022.]
- 23-61-1007. Insurance standards for individual qualified health insurance plans. [Effective until January 1, 2022.]
- 23-61-1008. [Expired.]
- 23-61-1009. Sunset. [Effective until January 1, 2022.]

A.C.R.C. Notes. Acts 2019, No. 722, § 25, provided: “ARKANSAS WORKS AND ARKANSAS HEALTH INSURANCE MARKETPLACE RESTRICTIONS.

“(a) As used in this section, ‘Arkansas Works’ means Arkansas Works established under the Arkansas Works Act of 2016, Arkansas Code § 23-61-1001 et seq.

“(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the State Insurance Department shall conduct outreach and education activities that meet the standards of 45 C.F.R. § 155.200(c), as existing on Janu-

ary 1, 2019, to educate consumers about the Arkansas Health Insurance Marketplace and insurance affordability programs to encourage participation, including without limitation the use of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, § 23-64-601 et seq.

“(2) The department shall not advertise, promote, or engage in other activities designed to promote or encourage enrollment in the Arkansas Works Program established by the Arkansas Works Act of 2016, § 23-61-1001 et seq., including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements in newspapers, magazines, or other print media; and

“(E) Advertisements on websites or other electronic media.

“(3) Subdivision (c)(2) of this section does not prohibit the department from:

“(A) Engaging in direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Engaging in solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential

recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the potential recipient might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(3)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using a website for the exclusive purpose of enrolling individuals in the program.

“(d) The department shall not apply for or accept any funds, including without limitation federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or the program.

“(e)(1) Biannually, the department shall report to the Legislative Council regarding the use of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, § 23-64-601 et seq.

“(2) The report shall include without limitation:

“(A) The number of navigators, guides, certified application counselors, and certified licensed producers;

“(B) The number of recipients assisted by the navigators, guides, certified application counselors, and certified licensed producers to obtain coverage; and

“(C) The number of recipients assisted by the navigators, guides, certified application counselors, and certified licensed producers to obtain coverage and who obtained coverage through the program.

“(f) This section expires on June 30, 2020.”

Acts 2021, No. 843, § 13, provides: **“ARKANSAS HEALTH AND OPPORTUNITY FOR ME AND ARKANSAS HEALTH INSURANCE MARKETPLACE RESTRICTIONS.**

“(a) As used in this section, ‘Arkansas Health and Opportunity for Me’ means Arkansas Health and Opportunity for Me established under the Arkansas Health and Opportunity for Me Act of 2021, Arkansas Code § 23-61-1001 et seq.

“(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what purposes an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the Department of Human Services shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me, including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements printed in newspapers, magazines, or other print media; and

“(E) Internet websites and electronic media.

“(2) This subsection does not prohibit the department from:

“(A) Direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational

materials or information regarding any coverage for which the individual might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me.

“(d) The Department of Human Services shall not apply for or accept any funds, including without limitation federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me.

“(e)(1) Except as provided in subdivision (e)(2) of this section, the Department of Human Services shall not:

“(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

“(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

“(f) An appropriation authorized by the General Assembly shall not be subject to the provisions allowed through reallocation of resources or transfer of appropriation authority for the purpose of transferring an appropriation to any other appropriation authorized for the Department of Human Services to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

“(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

“(h) This section expires on June 30, 2022.”

Preambles. Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, contained a preamble which read:

“WHEREAS, the State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage employer-based insurance, incentivize program beneficiaries to work or seek work opportunities, promote personal responsibility, and enhance program integrity; and

“WHEREAS, the General Assembly affirms its responsibility to safeguard consumers and businesses from federal mandates by asserting local control and implementation of modernized health insurance policies and programs that utilize the private market to improve access to health insurance, enhance the quality of health insurance, and reduce health insurance costs; and

“WHEREAS, Arkansas recognizes the need to encourage employment among beneficiaries of public assistance programs, offer enhanced opportunities for beneficiaries to obtain jobs and job training, and endow beneficiaries with the tools to achieve economic advancement; and

“WHEREAS, the Health Care Independence Program will terminate on December 31, 2016; and

“WHEREAS, the General Assembly hereby creates the Arkansas Works Act of 2016 to provide health insurance to qualifying individuals, NOW THEREFORE, ...”

Effective Dates. Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, § 9: Apr. 8, 2016. Emergency clause provided: “It is

found and determined by the General Assembly of the State of Arkansas that the federal laws established by Pub. L. No. 111-148, have caused disruptive challenges to the State of Arkansas in the health insurance industry and the medical assistance industry; that the Arkansas Works Program utilizes the private insurance market to improve access to health insurance, enhances quality of health insurance, and reduces health insurance and medical assistance costs; that the Arkansas Works Program requires private insurance companies and employers to create, present, implement, and market a new type of health insurance policy; and that this act is immediately necessary because the private insurance companies and employers need certainty about the law creating the Arkansas Works Program before fully investing time, funds, personnel, and other resources into the development of new health insurance policies. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 10: Dec. 31, 2017. Effective date clause provided: "Section 5 of this act is effective on and after December 31, 2017."

Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 11: May 4, 2017. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act requires that the Department of Human Services submit a state plan amendment or waiver, or both, to the Centers for Medicare and

Medicaid Services; that the state plan amendment or waiver, or both, impacts certain individuals who are presently enrolled in the Arkansas Works Program; and that this act is immediately necessary because the Department of Human Services needs to be able to make the state plan amendment request or waiver request, or both, at the earliest possible date to ensure certainty in the requirements of the Arkansas Works Program. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled 'Funding and classification of cabinet-level department secretaries' and 'Transformation and Efficiencies Act transition team' should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019."

23-61-1001. Title. [Effective until January 1, 2022.]

This subchapter shall be known and may be cited as the "Arkansas Works Act of 2016".

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1.

23-61-1002. Legislative intent. [Effective until January 1, 2022.]

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the Arkansas Works Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

- (1) Empowers individuals to improve their economic security and achieve self-reliance;
- (2) Builds on private insurance market competition and value-based insurance purchasing models;
- (3) Strengthens the ability of employers to recruit and retain productive employees; and
- (4) Achieves comprehensive and innovative healthcare reform that reduces state and federal obligations for entitlement spending.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1.

23-61-1003. Definitions. [Effective until January 1, 2022.]

As used in this subchapter:

(1) “Cost-effective” means that the cost of covering employees who are:

(A) Program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through individual qualified health insurance plans; or

(B) Eligible individuals who are not program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through a program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2016;

(2) “Cost sharing” means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(3) “Eligible individual” means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

(4) “Employer health insurance coverage” means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(5) “Health insurance benefit plan” means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on January 1, 2016;

(6) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

(7) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society; or

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation;

(8) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer through the health insurance marketplace that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on January 1, 2016;

(9) "Premium" means a monthly fee that is required to be paid to maintain some or all health insurance benefits;

(10) "Program participant" means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined to be more effectively covered through the traditional Arkansas Medicaid Program, including without limitation:

(i) An individual who is medically frail; or

(ii) An individual who has exceptional medical needs for whom coverage offered through the health insurance marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care; and

(11)(A) "Small group plan" means a health insurance benefit plan for a small employer that employed an average of at least two (2) but no more than fifty (50) employees during the preceding calendar year.

(B) "Small group plan" does not include a grandfathered health insurance plan as defined in 45 C.F.R. § 147.140(a)(1)(i), as it existed on January 1, 2016.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2017 (1st Ex. Sess.), No. 3, § 4; 2017 (1st Ex. Sess.), No. 6, § 4.

A.C.R.C. Notes. Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) The State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage personal responsibility and enhance program integrity;

"(2) Arkansas recognizes the continued need to promote employment among beneficiaries of public assistance programs by providing those beneficiaries with the tools to achieve economic advancement;

"(3) Arkansas continues to support the flexibility within § 23-61-1004(h) that authorizes the Governor to 'request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose';

"(4) On March 6, 2017, Governor Asa Hutchinson announced additional reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance coverage provided under the Arkansas Works Program by:

"(A) Establishing a work requirement for certain beneficiaries of the Arkansas Works Program to encourage beneficiaries to work and to support beneficiaries in the process of returning to the workforce;

"(B) Capping eligibility for the Arkansas Works Program at one hundred percent (100%) of the federal poverty level; and

"(C) Returning control of the eligibility process to the state by allowing the state the flexibility to determine whether the state would be an 'assessment state' or a 'determination state'; and

"(5)(A) To avoid variations in enrollment within a Medicaid program based on an eligibility determination of a federally facilitated marketplace, Arkansas needs the flexibility to select whether to become an 'assessment state' or a 'determination state' in order to strengthen the integrity of the Medicaid Eligibility Verification System.

"(B) However, the Medicaid Eligibility Verification System established by Acts 2013, No. 1265, requires that the eligibility determination made by the federally facilitated marketplace be accepted by the Department of Human Services, which makes Arkansas a 'determination state' for the purposes of eligibility determination by a federally facilitated marketplace.

"(b) It is the intent of the General Assembly to:

"(1) Implement reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance provided under the Arkansas Works Program; and

"(2) Repeal §§ 20-77-2101 and 20-77-2103 to allow Arkansas the flexibility to select whether to become an 'assessment state' or a 'determination state' in order to strengthen the integrity of the Medicaid Eligibility Verification System."

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 3 and 6 substituted "meets the income eligibility standards established by rule of the Department of Human Services" for "is equal to or less than one hundred thirty-eight percent (138%) of the federal poverty level" in (10)(A).

23-61-1004. Administration of Arkansas Works Program. [Effective until January 1, 2022.]

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other necessary state agencies, shall:

(A) Provide health insurance or medical assistance under this subchapter to eligible individuals;

(B) Create and administer the Arkansas Works Program;

(C) Submit and apply for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the Arkansas Works Program in a manner consistent with this subchapter;

(D) Offer incentive benefits to promote personal responsibility; and

(E) Seek a waiver to eliminate retroactive eligibility for an eligible individual under this subchapter.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the Arkansas Works Program.

(b) Health insurance benefits under this subchapter shall be provided through:

(1) Individual premium assistance for enrollment of Arkansas Works Program participants in individual qualified health insurance plans; and

(2) Supplemental benefits to incentivize personal responsibility.

(c) The Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall promulgate and administer rules to implement the Arkansas Works Program.

(d)(1) Within thirty (30) days of a reduction in federal medical assistance percentages as described in this section, the Department of Human Services shall present to the Centers for Medicare & Medicaid Services a plan to terminate the Arkansas Works Program and transition eligible individuals out of the Arkansas Works Program within one hundred twenty (120) days of a reduction in any of the following federal medical assistance percentages:

(A) Ninety-five percent (95%) in the year 2017;

(B) Ninety-four percent (94%) in the year 2018;

(C) Ninety-three percent (93%) in the year 2019; and

(D) Ninety percent (90%) in the year 2020 or any year after the year 2020.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the Arkansas Works Program and the transition of eligible individuals out of the Arkansas Works Program.

(e) State obligations for uncompensated care shall be tracked and reported to identify potential incremental future decreases.

(f) The Department of Human Services shall track the hospital assessment fee imposed by § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.

(g)(1) On a quarterly basis, the Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding the overall Arkansas Works Program, including without limitation:

- (A) Eligibility and enrollment;
- (B) Utilization;
- (C) Premium and cost-sharing reduction costs;
- (D) Health insurer participation and competition;
- (E) Avoided uncompensated care; and
- (F) Participation in job training and job search programs.

(2)(A) A health insurer who is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the State Insurance Department to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

(B) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2017 (1st Ex. Sess.), No. 3, § 5; 2017 (1st Ex. Sess.), No. 6, § 5; 2019, No. 910, §§ 600, 601.

A.C.R.C. Notes. Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) The State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage personal responsibility and enhance program integrity;

"(2) Arkansas recognizes the continued need to promote employment among beneficiaries of public assistance programs by providing those beneficiaries with the tools to achieve economic advancement;

"(3) Arkansas continues to support the flexibility within § 23-61-1004(h) that au-

thorizes the Governor to 'request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose';

"(4) On March 6, 2017, Governor Asa Hutchinson announced additional reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance coverage provided under the Arkansas Works Program by:

"(A) Establishing a work requirement for certain beneficiaries of the Arkansas Works Program to encourage beneficiaries to work and to support beneficiaries in the process of returning to the workforce;

"(B) Capping eligibility for the Arkansas Works Program at one hundred percent (100%) of the federal poverty level; and

“(C) Returning control of the eligibility process to the state by allowing the state the flexibility to determine whether the state would be an ‘assessment state’ or a ‘determination state’; and

“(5)(A) To avoid variations in enrollment within a Medicaid program based on an eligibility determination of a federally facilitated marketplace, Arkansas needs the flexibility to select whether to become an ‘assessment state’ or a ‘determination state’ in order to strengthen the integrity of the Medicaid Eligibility Verification System.

“(B) However, the Medicaid Eligibility Verification System established by Acts 2013, No. 1265, requires that the eligibility determination made by the federally facilitated marketplace be accepted by the Department of Human Services, which makes Arkansas a ‘determination state’ for the purposes of eligibility determination by a federally facilitated marketplace.

“(b) It is the intent of the General As-

sembly to:

“(1) Implement reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance provided under the Arkansas Works Program; and

“(2) Repeal §§ 20-77-2101 and 20-77-2103 to allow Arkansas the flexibility to select whether to become an ‘assessment state’ or a ‘determination state’ in order to strengthen the integrity of the Medicaid Eligibility Verification System.”

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 3 and 6 deleted former (b)(2).

The 2019 amendment substituted “Division of Workforce Services” for “Department of Workforce Services” in (c) and the introductory paragraph of (g)(1).

Effective Dates. Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 10: Dec. 31, 2017. Effective date clause provided: “Section 5 of this act is effective on and after December 31, 2017.”

23-61-1005. Requirements for eligible individuals. [Effective until January 1, 2022.]

(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:

(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and

(B) The first year of, and thereafter annually:

(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or

(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.

(2) Failure to meet the requirement in subdivision (a)(1) of this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.

(b)(1) An eligible individual who has up to fifty percent (50%) of the federal poverty level at the time of an eligibility determination shall be referred to the Division of Workforce Services to:

(A) Incentivize and increase work and work training opportunities; and

(B) Participate in job training and job search programs.

(2) The Department of Human Services or its designee shall provide work training opportunities, outreach, and education about work and

work training opportunities through the Division of Workforce Services to all eligible individuals regardless of income at the time of an eligibility determination.

(c) An eligible individual shall receive notice that:

(1) The Arkansas Works Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The Arkansas Works Program is subject to cancellation upon appropriate notice; and

(3) The Arkansas Works Program is not an entitlement program.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2019, No. 910, §§ 602, 603.

A.C.R.C. Notes. As enacted, the introductory language of subdivision (b)(1) appears to be missing language essential to

its meaning.

Amendments. The 2019 amendment, in the introductory language of (b)(1) and in (b)(2), substituted “Division of Workforce Services” for “Department of Workforce Services”.

23-61-1006. Requirements for program participants. [Effective until January 1, 2022.]

(a) A program participant who is twenty-one (21) years of age or older shall enroll in employer health insurance coverage if the employer health insurance coverage meets the standards in § 23-61-1008(a).

(b)(1) A program participant who has income of at least one hundred percent (100%) of the federal poverty level shall pay a premium of no more than two percent (2%) of the income to a health insurer.

(2) Failure by the program participant to meet the requirement in subdivision (b)(1) of this section may result in:

(A) The accrual of a debt to the State of Arkansas; and

(B)(i) The loss of incentive benefits in the event of failure to pay premiums for three (3) consecutive months, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.

(ii) However, incentive benefits shall be restored if a program participant pays all premiums owed.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1.

23-61-1007. Insurance standards for individual qualified health insurance plans. [Effective until January 1, 2022.]

(a) Insurance coverage for a program participant enrolled in an individual qualified health insurance plan shall be obtained through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on January 1, 2016, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) The Department of Human Services shall pay premiums and supplemental cost sharing reductions directly to a health insurer for a

program participant enrolled in an individual qualified health insurance plan.

(c) All participating health insurers offering individual qualified health insurance plans in the health insurance marketplace shall:

(1)(A) Offer individual qualified health insurance plans conforming to the requirements of this section and applicable insurance rules.

(B) The individual qualified health insurance plans shall be approved by the State Insurance Department; and

(2) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on January 1, 2016, or rebate the difference to the Department of Human Services for program participants.

(d) The State of Arkansas shall assure that at least two (2) individual qualified health insurance plans are offered in each county in the state.

(e) A health insurer offering individual qualified health insurance plans for program participants shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including program participants, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(f) On or before January 1, 2017, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1.

23-61-1008. [Expired.]

Publisher's Notes. This section, concerning insurance standards for employer health insurance coverage, expired December 31, 2017, pursuant to identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, §

6. The section derived from Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2017 (1st Ex. Sess.), No. 3, § 6; 2017 (1st Ex. Sess.), No. 6, § 6.

23-61-1009. Sunset. [Effective until January 1, 2022.]

This subchapter shall expire on December 31, 2021.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; reen. Acts 2016 (3rd Ex. Sess.), No. 12, § 2; reen. Acts 2016 (3rd Ex. Sess.), No. 13, § 2.

A.C.R.C. Notes. Acts 2016, No. 3, § 19, which attempted to amend this section by altering the expiration date, was vetoed by the Governor. Because the General Assembly was unable to override the Gov-

ernor's veto, Acts 2016, No. 3, § 19, did not become law.

This section was reenacted by identical Acts 2016, Nos. 12 and 13, § 2.

Identical Acts 2016 (3rd Ex. Sess.), Nos. 12 and 13, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, were enacted and became effective on April 8, 2016;

"(2) Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, created the Arkansas Works Program, § 23-61-1001 et seq., and amended various sections of the Arkansas Code;

"(3) During the 2016 Fiscal Session, an amendment was made to Senate Bill 121, the appropriation bill of the Division of Medical Services of the Department of Human Services, to add Section 19 which modified the sunset date of the Arkansas Works Program from December 31, 2021, the date established by the identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, to December 31, 2016; and

"(4) On April 21, 2016, the Governor exercised the power of the line-item veto under the Arkansas Constitution, Article 6, § 17, to veto Section 19 of Senate Bill 121 and signed the bill, which became Acts 2016, No. 3.

"(b) It is the intent of the General Assembly to:

"(1) Recognize the power of the line-item veto under the Arkansas Constitution, Article 6, § 17, as exercised by the Governor; and

"(2) Demonstrate that the will of the General Assembly is for the sunset date of the Arkansas Works Program to be as originally established by identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2; and

"(3) Ensure the original sunset date of December 31, 2021, for the Arkansas Works Program established by identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, is reenacted in the event that a court invalidates the line-item veto of Section 19 of Senate Bill 121 as exercised by the Governor."

SUBCHAPTER 10 — ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 [EFFECTIVE JANUARY 1, 2022]

SECTION.

- 23-61-1001. Title. [Effective January 1, 2022.]
- 23-61-1002. Legislative intent. [Effective January 1, 2022.]
- 23-61-1003. Definitions. [Effective January 1, 2022.]
- 23-61-1004. Administration. [Effective January 1, 2022.]
- 23-61-1005. Requirements for eligible individuals. [Effective January 1, 2022.]
- 23-61-1006. Requirements for program participants. [Effective January 1, 2022.]
- 23-61-1007. Insurance standards for individual qualified health in-

SECTION.

- urance plans. [Effective January 1, 2022.]
- 23-61-1008. [Expired.]
- 23-61-1009. Sunset. [Effective January 1, 2022.]
- 23-61-1010. Community bridge organizations. [Effective January 1, 2022.]
- 23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel. [Effective January 1, 2022.]
- 23-61-1012. Rules. [Effective January 1, 2022.]

A.C.R.C. Notes. Acts 2021, No. 843, § 13, provides: "ARKANSAS HEALTH AND OPPORTUNITY FOR ME AND ARKANSAS HEALTH INSURANCE MARKET-PLACE RESTRICTIONS.

"(a) As used in this section, 'Arkansas Health and Opportunity for Me' means

Arkansas Health and Opportunity for Me established under the Arkansas Health and Opportunity for Me Act of 2021, Arkansas Code § 23-61-1001 et seq.

"(b)(1) Determining the maximum number of employees, the maximum amount of appropriation, for what pur-

poses an appropriation is authorized, and general revenue funding for a state agency each fiscal year is the prerogative of the General Assembly.

“(2) The purposes of subdivision (b)(1) of this section are typically accomplished by:

“(A) Identifying the purpose in the appropriation act;

“(B) Delineating such maximums in the appropriation act for a state agency; and

“(C) Delineating the general revenue allocations authorized for each fund and fund account by amendment to the Revenue Stabilization Law, Arkansas Code § 19-5-101 et seq.

“(3) It is both necessary and appropriate that the General Assembly restrict the use of appropriations authorized in this act.

“(c)(1) Except as provided in this subsection, the Department of Human Services shall not allocate, budget, expend, or utilize any appropriation authorized by the General Assembly for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me, including without limitation:

“(A) Unsolicited communications mailed to potential recipients;

“(B) Television, radio, or online commercials;

“(C) Billboard or mobile billboard advertising;

“(D) Advertisements printed in newspapers, magazines, or other print media; and

“(E) Internet websites and electronic media.

“(2) This subsection does not prohibit the department from:

“(A) Direct communications with:

“(i) Licensed insurance agents; and

“(ii) Persons licensed by the department;

“(B) Solicited communications with potential recipients;

“(C)(i) Responding to an inquiry regarding the coverage for which a potential recipient might be eligible, including without limitation providing educational materials or information regarding any coverage for which the individual might qualify.

“(ii) Educational materials and information distributed under subdivision (c)(2)(C)(i) of this section shall contain only factual information and shall not contain subjective statements regarding the coverage for which the potential recipient might be eligible; and

“(D) Using an Internet website for the exclusive purpose of enrolling individuals in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me.

“(d) The Department of Human Services shall not apply for or accept any funds, including without limitation federal funds, for the purpose of advertisement, promotion, or other activities designed to promote or encourage enrollment in the Arkansas Health Insurance Marketplace or Arkansas Health and Opportunity for Me.

“(e)(1) Except as provided in subdivision (e)(2) of this section, the Department of Human Services shall not:

“(A)(i) Except as provided in subdivision (e)(1)(A)(ii) of this section, allocate, budget, expend, or utilize an appropriation authorized by the General Assembly for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(ii) Subdivision (e)(1)(A)(i) of this section does not apply to regulatory and training responsibilities related to navigators, guides, certified application counselors, and certified licensed producers; and

“(B) Apply for or accept any funds, including without limitation federal funds, for the purpose of funding activities of navigators, guides, certified application counselors, and certified licensed producers under the Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act, Arkansas Code § 23-64-601 et seq.

“(2) Subdivision (e)(1) of this section does not apply to certified application counselors at health related institutions, including without limitation the University of Arkansas for Medical Sciences.

“(f) An appropriation authorized by the General Assembly shall not be subject to the provisions allowed through reallocation of resources or transfer of appropri-

tion authority for the purpose of transferring an appropriation to any other appropriation authorized for the Department of Human Services to be allocated, budgeted, expended, or utilized in a manner prohibited by this section.

“(g) The provisions of this section are severable, and the invalidity of any subsection or subdivision of this section shall not affect other provisions of the section that can be given effect without the invalid provision.

“(h) This section expires on June 30, 2022.”

Preambles. Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, contained a preamble which read:

“WHEREAS, the State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage employer-based insurance, incentivize program beneficiaries to work or seek work opportunities, promote personal responsibility, and enhance program integrity; and

“WHEREAS, the General Assembly affirms its responsibility to safeguard consumers and businesses from federal mandates by asserting local control and implementation of modernized health insurance policies and programs that utilize the private market to improve access to health insurance, enhance the quality of health insurance, and reduce health insurance costs; and

“WHEREAS, Arkansas recognizes the need to encourage employment among beneficiaries of public assistance programs, offer enhanced opportunities for beneficiaries to obtain jobs and job training, and endow beneficiaries with the tools to achieve economic advancement; and

“WHEREAS, the Health Care Independence Program will terminate on December 31, 2016; and

“WHEREAS, the General Assembly hereby creates the Arkansas Works Act of 2016 to provide health insurance to qualifying individuals, NOW THEREFORE, ...”

Effective Dates. Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, § 9: Apr. 8, 2016. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the federal laws established by Pub. L. No. 111-148, have caused disruptive chal-

lenges to the State of Arkansas in the health insurance industry and the medical assistance industry; that the Arkansas Works Program utilizes the private insurance market to improve access to health insurance, enhances quality of health insurance, and reduces health insurance and medical assistance costs; that the Arkansas Works Program requires private insurance companies and employers to create, present, implement, and market a new type of health insurance policy; and that this act is immediately necessary because the private insurance companies and employers need certainty about the law creating the Arkansas Works Program before fully investing time, funds, personnel, and other resources into the development of new health insurance policies. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 10: Dec. 31, 2017. Effective date clause provided: “Section 5 of this act is effective on and after December 31, 2017.”

Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 11: May 4, 2017. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act requires that the Department of Human Services submit a state plan amendment or waiver, or both, to the Centers for Medicare and Medicaid Services; that the state plan amendment or waiver, or both, impacts certain individuals who are presently enrolled in the Arkansas Works Program; and that this act is immediately necessary because the Department of Human Services needs to be able to make the state plan amendment request or waiver request, or both, at the earliest possible date to ensure certainty in the requirements of the Arkansas Works Program. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1)

The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.”

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections

of this act other than the two uncoded sections of this act preceding the emergency clause titled ‘Funding and classification of cabinet-level department secretaries’ and ‘Transformation and Efficiencies Act transition team’ should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019.”

Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1001. Title. [Effective January 1, 2022.]

This subchapter shall be known and may be cited as the “Arkansas Health and Opportunity for Me Act of 2021”.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2021, No. 530, § 1.

Amendments. The 2021 amendment substituted “Arkansas Health and Oppor-

tunity for Me Act of 2021” for “Arkansas Works Act of 2016”.

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1002. Legislative intent. [Effective January 1, 2022.]

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the Arkansas Health and Opportunity for Me Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

(1) Achieves comprehensive and innovative healthcare reform that reduces the rate of growth in state and federal obligations for providing healthcare coverage to low-income adults in Arkansas;

(2) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(3) Promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations;

(4) Encourages personal responsibility for individuals to demonstrate that they value healthcare coverage and understand their roles and obligations in maintaining private insurance coverage;

(5) Increases opportunities for full-time work and attainment of economic independence, especially for certain young adults, to reduce long-term poverty that is associated with additional risk for disease and premature death;

(6) Addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk for disease and premature death associated with living in a rural county;

(7) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals; and

(8) Fills gaps in the continuum of care for individuals in need of services for serious mental illness and substance use disorders.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2021, No. 530, § 1.

Amendments. The 2021 amendment substituted “Arkansas Health and Opportunity for Me Program” for “Arkansas

Works Program” in the introductory language; deleted former (1), (2), and (3); rewrote and redesignated (4) as (1); and added (2) through (8).

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1003. Definitions. [Effective January 1, 2022.]

As used in this subchapter:

(1) “Acute care hospital” means a hospital that:

(A) Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

(B) Is enrolled as a provider with the Arkansas Medicaid Program;

(2) “Birthing hospital” means a hospital in this state or in a border state that:

(A) Is licensed as a general hospital;

(B) Provides obstetrics services; and

(C) Is enrolled as a provider with the Arkansas Medicaid Program;

(3) “Community bridge organization” means an organization that is authorized by the Department of Human Services to participate in the economic independence initiative or the health improvement initiative to:

(A) Screen and refer Arkansans to resources available in their communities to address health-related social needs; and

(B) Assist eligible individuals identified as target populations most at risk of disease and premature death and who need a higher level of intervention to improve their health outcomes and succeed in meeting their long-term goals to achieve independence, including economic independence;

(4) “Cost sharing” means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(5) “Critical access hospital” means an acute care hospital that is:

(A) Designated by the Centers for Medicare & Medicaid Services as a critical access hospital; and

(B) Is enrolled as a provider in the Arkansas Medicaid Program;

(6) “Economic independence initiative” means an initiative developed by the Department of Human Services that is designed to promote economic stability by encouraging participation of program participants

to engage in full-time, full-year work, and to demonstrate the value of enrollment in an individual qualified health insurance plan through incentives and disincentives;

(7) "Eligible individual" means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

(8) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(9) "Health improvement initiative" means an initiative developed by an individual qualified health insurance plan or the Department of Human Services that is designed to encourage the participation of eligible individuals in health assessments and wellness programs, including fitness programs and smoking or tobacco cessation programs;

(10) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on January 1, 2021;

(11) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

(12) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society;

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation; or

(H) A risk-based provider organization licensed by the Insurance Commissioner under § 20-77-2704;

(13) "Healthcare coverage" means coverage provided under this subchapter through either an individual qualified health insurance plan, a risk-based provider organization, employer health insurance coverage, or the fee-for-service Arkansas Medicaid Program;

(14) “Individual qualified health insurance plan” means an individual health insurance benefit plan offered by a health insurer that participates in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on January 1, 2021;

(15) “Member” means a program participant who is enrolled in an individual qualified health insurance plan;

(16) “Premium” means a monthly fee that is required to be paid by or on behalf of an eligible individual to maintain some or all health insurance benefits;

(17) “Program participant” means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined by the Department of Human Services to be medically frail or eligible for services through a risk-based provider organization;

(18) “Risk-based provider organization” means the same as defined in § 20-77-2703; and

(19) “Small rural hospital” means a critical access hospital or a general hospital that:

(A) Is located in a rural area;

(B) Has fifty (50) or fewer staffed beds; and

(C) Is enrolled as a provider in the Arkansas Medicaid Program.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2017 (1st Ex. Sess.), No. 3, § 4; 2017 (1st Ex. Sess.), No. 6, § 4; 2021, No. 530, § 1.

A.C.R.C. Notes. Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 1, provided: “Legislative findings and intent.

“(a) The General Assembly finds that:

“(1) The State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage personal responsibility and enhance program integrity;

“(2) Arkansas recognizes the continued need to promote employment among beneficiaries of public assistance programs by providing those beneficiaries with the tools to achieve economic advancement;

“(3) Arkansas continues to support the flexibility within § 23-61-1004(h) that authorizes the Governor to ‘request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose’;

“(4) On March 6, 2017, Governor Asa Hutchinson announced additional reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance coverage provided under the Arkansas Works Program by:

“(A) Establishing a work requirement for certain beneficiaries of the Arkansas Works Program to encourage beneficiaries

to work and to support beneficiaries in the process of returning to the workforce;

“(B) Capping eligibility for the Arkansas Works Program at one hundred percent (100%) of the federal poverty level; and

“(C) Returning control of the eligibility process to the state by allowing the state the flexibility to determine whether the state would be an ‘assessment state’ or a ‘determination state’; and

“(5)(A) To avoid variations in enrollment within a Medicaid program based on an eligibility determination of a federally facilitated marketplace, Arkansas needs the flexibility to select whether to become an ‘assessment state’ or a ‘determination state’ in order to strengthen the integrity of the Medicaid Eligibility Verification System.

“(B) However, the Medicaid Eligibility Verification System established by Acts 2013, No. 1265, requires that the eligibility determination made by the federally facilitated marketplace be accepted by the Department of Human Services, which makes Arkansas a ‘determination state’ for the purposes of eligibility determination by a federally facilitated marketplace.

“(b) It is the intent of the General Assembly to:

“(1) Implement reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance provided under the Arkansas Works Program; and

“(2) Repeal §§ 20-77-2101 and 20-77-2103 to allow Arkansas the flexibility to select whether to become an ‘assessment state’ or a ‘determination state’ in order to strengthen the integrity of the Medicaid Eligibility Verification System.”

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 3 and 6 substituted “meets the income eligibility standards established by rule of the Department of Human Services” for “is equal to or less than one hundred thirty-eight percent (138%) of the federal poverty level” in (10)(A).

The 2021 amendment rewrote the section.

U.S. Code. The Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, referred to in this section, is codified generally as 29 U.S.C. § 1001 et seq.

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, is codified throughout Title 42 and other titles of the U.S. Code, including 42 U.S.C. § 300gg et seq. and 42 U.S.C. § 18001 et seq. Concerning health benefit exchanges, see 42 U.S.C. § 18031 et seq.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, referred to in this section, is codified throughout Title 42 and other titles of the U.S. Code. See, e.g., 42 U.S.C. § 601 et seq.; 8 U.S.C. § 1611 et seq.

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1004. Administration. [Effective January 1, 2022.]

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other state agencies, as necessary, shall:

(A) Provide healthcare coverage under this subchapter to eligible individuals;

(B) Create and administer the Arkansas Health and Opportunity for Me Program by:

(i) Applying for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the Arkansas Health and Opportunity for Me Program in a manner consistent with this subchapter; and

(ii) Administering the Arkansas Health and Opportunity for Me Program as approved by the Centers for Medicare & Medicaid Services;

(C)(i) Administer the economic independence initiative designed to reduce the short-term effects of the work penalty and the long-term effects of poverty on health outcomes among program participants through incentives and disincentives.

(ii) The Department of Human Services shall align the economic independence initiative with other state-administered work-related programs to the extent practicable;

(D) Screen, refer, and assist eligible individuals through community bridge organizations under agreements with the Department of Human Services;

(E) Offer incentives to promote personal responsibility, individual health, and economic independence through individual qualified health insurance plans and community bridge organizations; and

(F) Seek a waiver to reduce the period of retroactive eligibility for an eligible individual under this subchapter to thirty (30) days before the date of the application.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the Arkansas Health and Opportunity for Me Program.

(b) Healthcare coverage under this subchapter shall be provided through enrollment in:

(1) An individual qualified health insurance plan through a health insurer;

(2) A risk-based provider organization;

(3) An employer-sponsored health insurance coverage; or

(4) The fee-for-service Arkansas Medicaid Program.

(c) Annually, the Department of Human Services shall develop purchasing guidelines that:

(1) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including without limitation:

(A) The level of the plan;

(B) The amounts of allowable premiums;

(C) Cost sharing;

(D) Auto-assignment methodology; and

(E) The total per-member-per-month enrollment range; and

(2) Ensure that:

(A) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(B) The total payments to all of the individual qualified health insurance plans offered by the health insurers for eligible individuals combined do not exceed budget targets for the Arkansas Health and Opportunity for Me Program in each demonstration year that the Department of Human Services may achieve by:

(i) Setting in advance an enrollment range to represent the minimum and a maximum total monthly number of enrollees into all individual qualified health insurance plans no later than April 30 of each demonstration year in order for the individual qualified health insurance plans to file rates for the following demonstration year;

(ii) Temporarily suspending auto-assignment into the individual qualified health insurance plans at any time in a demonstration year if necessary, to remain within the enrollment range and budget targets for the demonstration year; and

(iii) Developing a methodology for random auto-assignment of program participants into the individual qualified health insurance plans after a suspension period has ended;

(C) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the Department of Human Services; and

(D) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(d)(1) The Department of Human Services, the State Insurance Department, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Arkansas Health and Opportunity for Me Program, including provisions necessary to effectuate the purchasing guidelines and reporting requirements, at least thirty (30) calendar days before the annual open enrollment period.

(2) If a memorandum of understanding is not fully executed with a health insurer by January 1 of each new demonstration year, the Department of Human Services shall suspend auto-assignment of new members to the health insurers until the first day of the month after the new memorandum of understanding is fully executed.

(3) The memorandum of understanding shall include financial sanctions determined appropriate by the Department of Human Services that may be applied if the Department of Human Services determines that an individual qualified health insurance plan has not met the quality and performance measurement targets or any other condition of the memorandum of understanding.

(4)(A) If the Department of Human Services determines that the individual qualified health insurance plans have not met the quality and health performance targets for two (2) years, the Department of Human Services shall develop additional reforms to achieve the quality and health performance targets.

(B) If legislative action is required to implement the additional reforms described in subdivision (d)(4)(A) of this section, the Department of Human Services may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action.

(e) The Department of Human Services shall:

(1) Adopt premiums and cost-sharing levels for individuals enrolled in the Arkansas Health and Opportunity for Me Program, not to exceed aggregate limits under 42 C.F.R. § 447.56;

(2)(A) Establish and maintain a process for premium payments, advanced cost-sharing reduction payments, and reconciliation payments to health insurers.

(B) The process described in subdivision (e)(2)(A) of this section shall attribute any unpaid member liabilities as solely the financial obligation of the individual member.

(C) The Department of Human Services shall not include any unpaid individual member obligation in any payment or financial reconciliation with health insurers or in a future premium rate; and (3)(A) Calculate a total per-member-per-month amount for each individual qualified health insurance plan based on all payments made by the Department of Human Services on behalf of an individual enrolled in the individual qualified health insurance plan.

(B)(i) The amount described in subdivision (e)(3)(A) of this section shall include premium payments, advanced cost-sharing reduction payments for services provided to covered individuals during the demonstration year, and any other payments accruing to the budget neutrality target for plan-enrolled individuals made during the demonstration year and the member months for each demonstration year.

(ii) The total per-member-per-month upper limit is the budget neutrality per-member-per-month limit established in the approved demonstration for each demonstration year.

(C) If the Department of Human Services calculates that the total per-member-per-month limit for an individual qualified health insurance plan for that demonstration year exceeds the budget neutrality per-member-per-month limit for that demonstration year, the Department of Human Services shall not make any additional reconciliation payments to the health insurer for that individual qualified health insurance plan.

(D) If the Department of Human Services determines that the budget neutrality limit has been exceeded, the Department of Human Services shall recover the excess funds from the health insurer for that individual qualified health insurance plan.

(f)(1) If the federal medical assistance percentages for the Arkansas Health and Opportunity for Me Program are reduced to below ninety percent (90%), the Department of Human Services shall present to the Centers for Medicare & Medicaid Services a plan within thirty (30) days of the reduction to terminate the Arkansas Health and Opportunity for Me Program and transition eligible individuals out of the Arkansas Health and Opportunity for Me Program within one hundred twenty (120) days of the reduction.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the Arkansas Health and Opportunity for Me Program and the transition of eligible individuals out of the Arkansas Health and Opportunity for Me Program.

(g)(1) A health insurer that is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the Department of Human Services to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

(2) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h)(1) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

(2) The Governor shall request a waiver under relevant federal law and regulations for a work requirement as a condition of maintaining coverage in the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a waiver for this purpose.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2017 (1st Ex. Sess.), No. 3, § 5; 2017 (1st Ex. Sess.), No. 6, § 5; 2019, No. 910, §§ 600, 601; 2021, No. 530, § 1.

A.C.R.C. Notes. Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) The State of Arkansas continues to seek strategies to provide health insurance for low-income and other vulnerable populations in a manner that will encourage personal responsibility and enhance program integrity;

"(2) Arkansas recognizes the continued need to promote employment among beneficiaries of public assistance programs by providing those beneficiaries with the tools to achieve economic advancement;

"(3) Arkansas continues to support the flexibility within § 23-61-1004(h) that authorizes the Governor to request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose';

"(4) On March 6, 2017, Governor Asa Hutchinson announced additional reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance coverage provided under the Arkansas Works Program by:

"(A) Establishing a work requirement for certain beneficiaries of the Arkansas

Works Program to encourage beneficiaries to work and to support beneficiaries in the process of returning to the workforce;

"(B) Capping eligibility for the Arkansas Works Program at one hundred percent (100%) of the federal poverty level; and

"(C) Returning control of the eligibility process to the state by allowing the state the flexibility to determine whether the state would be an 'assessment state' or a 'determination state'; and

"(5)(A) To avoid variations in enrollment within a Medicaid program based on an eligibility determination of a federally facilitated marketplace, Arkansas needs the flexibility to select whether to become an 'assessment state' or a 'determination state' in order to strengthen the integrity of the Medicaid Eligibility Verification System.

"(B) However, the Medicaid Eligibility Verification System established by Acts 2013, No. 1265, requires that the eligibility determination made by the federally facilitated marketplace be accepted by the Department of Human Services, which makes Arkansas a 'determination state' for the purposes of eligibility determination by a federally facilitated marketplace.

"(b) It is the intent of the General Assembly to:

"(1) Implement reforms to the Arkansas Works Program to further support efficiency and sustainability of the health insurance provided under the Arkansas Works Program; and

“(2) Repeal §§ 20-77-2101 and 20-77-2103 to allow Arkansas the flexibility to select whether to become an ‘assessment state’ or a ‘determination state’ in order to strengthen the integrity of the Medicaid Eligibility Verification System.”

Amendments. The 2017 (1st Ex. Sess.) amendment by identical acts Nos. 3 and 6 deleted former (b)(2).

The 2019 amendment substituted “Division of Workforce Services” for “Depart-

ment of Workforce Services” in (c) and the introductory paragraph of (g)(1).

The 2021 amendment deleted “of Arkansas Works Program” from the section heading; and rewrote the section.

Effective Dates. Identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, § 10: Dec. 31, 2017. Effective date clause provided: “Section 5 of this act is effective on and after December 31, 2017.”

Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1005. Requirements for eligible individuals. [Effective January 1, 2022.]

(a) An eligible individual is responsible for all applicable cost-sharing and premium payment requirements as determined by the Department of Human Services.

(b) An eligible individual may participate in a health improvement initiative, as developed and implemented by either the eligible individual’s individual qualified health insurance plan or the department.

(c)(1)(A) An eligible individual who is determined by the department to meet the eligibility criteria for a risk-based provider organization due to serious mental illness or substance use disorder shall be enrolled in a risk-based provider organization under criteria established by the department.

(B) An eligible individual who is enrolled in a risk-based provider organization is exempt from the requirements of subsections (a) and (b) of this section.

(2)(A) An eligible individual who is determined by the department to be medically frail shall receive healthcare coverage through the fee-for-service Arkansas Medicaid Program.

(B) An eligible individual who is enrolled in the fee-for-service Arkansas Medicaid Program is exempt from the requirements of subsection (a) of this section.

(d) An eligible individual shall receive notice that:

(1) The Arkansas Health and Opportunity for Me Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The Arkansas Health and Opportunity for Me Program is subject to cancellation upon appropriate notice;

(3) Enrollment in an individual qualified health insurance plan is not a right; and

(4) If the individual chooses not to participate or fails to meet participation goals in the economic independence initiative, the individual may lose incentives provided through enrollment in an individual qualified health insurance plan or be unenrolled from the individual qualified health insurance plan after notification by the department.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2019, No. 910, §§ 602, 603; 2021, No. 530, § 1.

A.C.R.C. Notes. As enacted, the introductory language of subdivision (b)(1) appears to be missing language essential to its meaning.

Amendments. The 2019 amendment,

in the introductory language of (b)(1) and in (b)(2), substituted "Division of Workforce Services" for "Department of Workforce Services".

The 2021 amendment rewrote the section.

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1006. Requirements for program participants. [Effective January 1, 2022.]

(a) The economic independence initiative applies to all program participants in accordance with the implementation schedule of the Department of Human Services.

(b) Incentives established by the department for participation in the economic independence initiative and the health improvement initiative may include, without limitation, the waiver of premium payments and cost-sharing requirements as determined by the department for participation in one (1) or more initiatives.

(c) Failure by a program participant to meet the cost-sharing and premium payment requirement under § 23-61-1005(a) may result in the accrual of a personal debt to the health insurer or provider.

(d)(1)(A) Failure by the program participant to meet the initiative participation requirements of subsection (b) of this section may result in:

(i) Being unenrolled from the individual qualified health insurance plan; or

(ii) The loss of incentives, as defined by the department.

(B) However, an individual who is unenrolled shall not lose Medicaid healthcare coverage based solely on disenrollment from the individual qualified health insurance plan.

(2) The department shall develop and notify program participants of the criteria for restoring eligibility for incentive benefits that were removed as a result of the program participants' failure to meet the initiative participation requirements of subsection (b) of this section.

(3)(A) A program participant who also meets the criteria of a community bridge organization target population may qualify for additional incentives by successfully completing the economic independence initiative provided through a community bridge organization.

(B) If successfully completing the initiative results in an increase in the program participant's income that exceeds the program's financial eligibility limits, a program participant may receive, for a specified period of time, financial assistance to pay:

(i) The individual's share of employer-sponsored health insurance coverage not to exceed a limit determined by the department; or

(ii) A share of the individual's cost-sharing obligation, as determined by the department, if the individual enrolls in a health insurance benefit plan offered through the Arkansas Health Insurance Marketplace.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2021, No. 530, § 1.
Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

Amendments. The 2021 amendment rewrote the section.

23-61-1007. Insurance standards for individual qualified health insurance plans. [Effective January 1, 2022.]

(a) Insurance coverage for a member enrolled in an individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on January 1, 2021, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) As provided under § 23-61-1004(e)(2), health insurers shall track the applicable premium payments and cost sharing collected from members to ensure that the total amount of an individual's payments for premiums and cost sharing does not exceed the aggregate cap imposed by 42 C.F.R. § 447.56.

(c) All health benefit plans purchased by the Department of Human Services shall:

(1) Conform to the requirements of this section and applicable insurance rules;

(2) Be certified by the State Insurance Department;

(3)(A) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on January 1, 2021, or rebate the difference to the Department of Human Services for members.

(B) However, the Department of Human Services may approve up to one percent (1%) of revenues as community investments and as benefit expenses in calculating the medical-loss ratio of a plan in accordance with 45 C.F.R. § 158.150;

(4) Develop:

(A) An annual quality assessment and performance improvement strategic plan to be approved by the Department of Human Services that aligns with federal quality improvement initiatives and quality and reporting requirements of the Department of Human Services; and

(B) Targeted initiatives based on requirements established by the Department of Human Services in consultation with the Department of Health; and

(5) Make reports to the Department of Human Services and the Department of Health regarding quality and performance metrics in a manner and frequency established by a memorandum of understanding.

(d) A health insurer offering individual qualified health insurance plans for members shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including members, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(e)(1) Each individual qualified health insurance plan shall provide for a health improvement initiative, subject to the review and approval of the Department of Human Services, to provide incentives to its enrolled members to participate in one (1) or more health improvement initiatives as defined in § 23-61-1003(9).

(2)(A) The Department of Human Services shall work with health insurers offering individual qualified health insurance plans to ensure the economic independence initiative offered by the health insurer includes a robust outreach and communications effort which targets specific health, education, training, employment, and other opportunities appropriate for its enrolled members.

(B) The outreach and communications effort shall recognize that enrolled members receive information from multiple channels, including without limitation:

(i) Community service organizations;

(ii) Local community outreach partners;

(iii) Email;

(iv) Radio;

(v) Religious organizations;

(vi) Social media;

(vii) Television;

(viii) Text message; and

(ix) Traditional methods such as newspaper or mail.

(f) On or before January 1, 2022, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2021, No. 530, § 1.

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

Amendments. The 2021 amendment rewrote the section.

23-61-1008. [Expired.]

Publisher's Notes. This section, concerning insurance standards for employer health insurance coverage, expired December 31, 2017, pursuant to identical Acts 2017 (1st Ex. Sess.), Nos. 3 and 6, §

6. The section derived from Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; 2017 (1st Ex. Sess.), No. 3, § 6; 2017 (1st Ex. Sess.), No. 6, § 6.

23-61-1009. Sunset. [Effective January 1, 2022.]

This subchapter shall expire on December 31, 2026.

History. Acts 2016 (2nd Ex. Sess.), No. 1, § 1; 2016 (2nd Ex. Sess.), No. 2, § 1; reen. Acts 2016 (3rd Ex. Sess.), No. 12, § 2; reen. Acts 2016 (3rd Ex. Sess.), No. 13, § 2; 2021, No. 530, § 1.

A.C.R.C. Notes. Acts 2016, No. 3, § 19, which attempted to amend this section by altering the expiration date, was vetoed by the Governor. Because the General Assembly was unable to override the Governor's veto, Acts 2016, No. 3, § 19, did not become law.

This section was reenacted by identical Acts 2016, Nos. 12 and 13, § 2.

Identical Acts 2016 (3rd Ex. Sess.), Nos. 12 and 13, § 1, provided: "Legislative findings and intent.

"(a) The General Assembly finds that:

"(1) Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, were enacted and became effective on April 8, 2016;

"(2) Identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, created the Arkansas Works Program, § 23-61-1001 et seq., and amended various sections of the Arkansas Code;

"(3) During the 2016 Fiscal Session, an amendment was made to Senate Bill 121, the appropriation bill of the Division of Medical Services of the Department of Human Services, to add Section 19 which modified the sunset date of the Arkansas Works Program from December 31, 2021,

the date established by the identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, to December 31, 2016; and

"(4) On April 21, 2016, the Governor exercised the power of the line-item veto under the Arkansas Constitution, Article 6, § 17, to veto Section 19 of Senate Bill 121 and signed the bill, which became Acts 2016, No. 3.

"(b) It is the intent of the General Assembly to:

"(1) Recognize the power of the line-item veto under the Arkansas Constitution, Article 6, § 17, as exercised by the Governor; and

"(2) Demonstrate that the will of the General Assembly is for the sunset date of the Arkansas Works Program to be as originally established by identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2; and

"(3) Ensure the original sunset date of December 31, 2021, for the Arkansas Works Program established by identical Acts 2016 (2nd Ex. Sess.), Nos. 1 and 2, is reenacted in the event that a court invalidates the line-item veto of Section 19 of Senate Bill 121 as exercised by the Governor."

Amendments. The 2021 amendment substituted "December 31, 2026" for "December 31, 2021".

Effective Dates. Acts 2021, No. 530, § 9: Jan. 1, 2022.

23-61-1010. Community bridge organizations. [Effective January 1, 2022.]

(a) The Department of Human Services shall develop requirements and qualifications for community bridge organizations to provide assistance to one (1) or more of the following target populations:

(1) Individuals who become pregnant with a high-risk pregnancy and the child, throughout the pregnancy and up to twenty-four (24) months after birth;

(2) Individuals in rural areas of the state in need of treatment for serious mental illness or substance use disorder;

(3) Individuals who are young adults most at risk of poor health due to long-term poverty and who meet criteria established by the Department of Human Services, including without limitation the following:

(A) An individual between nineteen (19) and twenty-four (24) years of age who has been previously placed under the supervision of the:

(i) Division of Youth Services; or

(ii) Department of Corrections;

(B) An individual between nineteen (19) and twenty-seven (27) years of age who has been previously placed under the supervision of the Division of Children and Family Services; or

(C) An individual between nineteen (19) and thirty (30) years of age who is a veteran; and

(4) Any other target populations identified by the Department of Human Services.

(b)(1) Each community bridge organization shall be administered by a hospital under conditions established by the Department of Human Services.

(2) A hospital is eligible to serve eligible individuals under subdivision (a)(1) of this section if the hospital:

(A) Is a birthing hospital;

(B) Provides or contracts with a qualified entity for the provision of a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth; and

(C) Meets any additional criteria established by the Department of Human Services.

(3)(A) A hospital is eligible to serve eligible individuals under subdivision (a)(2) of this section if the hospital:

(i) Is a small rural hospital;

(ii) Screens all Arkansans who seek services at the hospital for health-related social needs;

(iii) Refers Arkansans identified as having health-related social needs for social services available in the community;

(iv) Employs local qualified staff to assist eligible individuals in need of treatment for serious mental illness or substance use disorder in accessing medical treatment from healthcare professionals and supports to meet health-related social needs;

(v) Enrolls with the Arkansas Medicaid Program as an acute crisis unit provider; and

(vi) Meets any additional criteria established by the Department of Human Services.

(B) The hospital may use funding available through the Department of Human Services to improve the hospital's ability to deliver care through coordination with other healthcare professionals and with the local emergency response system that may include training of personnel and improvements in equipment to support the delivery of medical services through telemedicine.

(4) A hospital is eligible to serve eligible individuals under subdivision (a)(3) of this section if the hospital:

(A) Is an acute care hospital;

(B) Administers or contracts for the administration of programs using proven models, as defined by the Department of Human Services, to provide employment, training, education, or other social supports; and

(C) Meets any additional criteria established by the Department of Human Services.

(c) An individual is not required or entitled to enroll in a community bridge organization as a condition of Medicaid eligibility.

(d) A hospital is not:

(1) Required to apply to become a community bridge organization; or

(2) Entitled to be selected as a community bridge organization.

History. Acts 2021, No. 530, § 1.

Effective Dates. Acts 2021, No. 530,

§ 9: Jan. 1, 2022.

23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel. [Effective January 1, 2022.]

(a) There is created the Health and Economic Outcomes Accountability Oversight Advisory Panel.

(b) The advisory panel shall be composed of the following members:

(1) The following members of the General Assembly:

(A) The Chair of the Senate Committee on Public Health, Welfare, and Labor;

(B) The Chair of the House Committee on Public Health, Welfare, and Labor;

(C) The Chair of the Senate Committee on Education;

(D) The Chair of the House Committee on Education;

(E) The Chair of the Senate Committee on Insurance and Commerce;

(F) The Chair of the House Committee on Insurance and Commerce;

(G) An at-large member of the Senate appointed by the President Pro Tempore of the Senate;

(H) An at-large member of the House of Representatives appointed by the Speaker of the House of Representatives;

(I) An at-large member of the Senate appointed by the minority leader of the Senate; and

(J) An at-large member of the House of Representatives appointed by the minority leader of the House of Representatives;

(2) The Secretary of the Department of Human Services;

(3) The Arkansas Surgeon General;

(4) The Insurance Commissioner;

(5) The heads of the following executive branch agencies or their designees:

(A) Department of Health;

(B) Department of Education;

(C) Department of Corrections;

(D) Department of Commerce; and

(E) Department of Finance and Administration;

(6) The Executive Director of the Arkansas Minority Health Commission; and

(7)(A) Three (3) community members who represent health, business, or education, who reflect the broad racial and geographic diversity in the state, and who have demonstrated a commitment to improving the health and welfare of Arkansans, appointed as follows:

(i) One (1) member shall be appointed by and serve at the will of the Governor;

(ii) One (1) member shall be appointed by and serve at the will of the President Pro Tempore of the Senate; and

(iii) One (1) member shall be appointed by and serve at the will of the Speaker of the House of Representatives.

(B) Members serving under subdivision (b)(7)(A) of this section may receive mileage reimbursement.

(c)(1) The Secretary of the Department of Human Services and one (1) legislative member shall serve as the cochairs of the Health and Economic Outcomes Accountability Oversight Advisory Panel and shall convene meetings quarterly of the advisory panel.

(2) The legislative member who serves as the cochair shall be selected by majority vote of all legislative members serving on the advisory panel.

(d)(1) The advisory panel shall review, make nonbinding recommendations, and provide advice concerning the proposed quality performance targets presented by the Department of Human Services for each participating individual qualified health insurance plan.

(2) The advisory panel shall deliver all nonbinding recommendations to the Secretary of the Department of Human Services.

(3)(A) The Secretary of the Department of Human Services, in consultation with the State Medicaid Director, shall determine all quality performance targets for each participating individual qualified health insurance plan.

(B) The Secretary of the Department of Human Services may consider the nonbinding recommendations of the advisory panel when determining quality performance targets for each participating individual qualified health insurance plan.

(e) The advisory panel shall review:

(1) The annual quality assessment and performance improvement strategic plan for each participating individual qualified health insurance plan;

(2) Financial performance of the Arkansas Health and Opportunity for Me Program against the budget neutrality targets in each demonstration year;

(3) Quarterly reports prepared by the Department of Human Services, in consultation with the Department of Commerce, on progress towards meeting economic independence outcomes and health improvement outcomes, including without limitation:

(A) Community bridge organization outcomes;

(B) Individual qualified health insurance plan health improvement outcomes;

(C) Economic independence initiative outcomes; and

(D) Any sanctions or penalties assessed on participating individual qualified health insurance plans;

(4) Quarterly reports prepared by the Department of Human Services on the Arkansas Health and Opportunity for Me Program, including without limitation:

(A) Eligibility and enrollment;

(B) Utilization;

(C) Premium and cost-sharing reduction costs; and

(D) Health insurer participation and competition; and

(5) Any other topics as requested by the Secretary of the Department of Human Services.

(f)(1) The advisory panel may furnish advice, gather information, make recommendations, and publish reports.

(2) However, the advisory panel shall not administer any portion of the Arkansas Health and Opportunity for Me Program or set policy.

(g) The Department of Human Services shall provide administrative support necessary for the advisory panel to perform its duties.

(h) The Department of Human Services shall produce and submit a quarterly report incorporating the advisory panel's findings to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the public on the progress in health and economic improvement resulting from the Arkansas Health and Opportunity for Me Program, including without limitation:

(1) Eligibility and enrollment;

(2) Participation in and the impact of the economic independence initiative and the health improvement initiative of the eligible individuals, health insurers, and community bridge organizations;

(3) Utilization of medical services;

(4) Premium and cost-sharing reduction costs; and

(5) Health insurer participation and completion.

History. Acts 2021, No. 530, § 1.

Effective Dates. Acts 2021, No. 530,

§ 9: Jan. 1, 2022.

23-61-1012. Rules. [Effective January 1, 2022.]

The Department of Human Services shall adopt rules necessary to implement this subchapter.

History. Acts 2021, No. 530, § 1.

Effective Dates. Acts 2021, No. 530,

§ 9: Jan. 1, 2022.

SUBCHAPTER 11 — STATE BOARD OF EMBALMERS, FUNERAL DIRECTORS, CEMETERIES, AND BURIAL SERVICES

SECTION.

23-61-1101. Definitions.

SECTION.

23-61-1102. Creation — Members.

SECTION.

- 23-61-1103. Powers and duties.
- 23-61-1104. Executive Secretary of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.
- 23-61-1105. Embalmers and funeral directors.
- 23-61-1106. Inspector of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services — Funeral

SECTION.

- directing — Embalming, cremating, or transporting human remains.
- 23-61-1107. Crematoriums.
- 23-61-1108. Transportation of dead human bodies.
- 23-61-1109. Cemeteries and cemetery companies.
- 23-61-1110. Burial associations.
- 23-61-1111. Duties of State Insurance Department.

A.C.R.C. Notes. Acts 2017, No. 788, § 1, provided: “Abolition of the Arkansas Cemetery Board, the State Board of Embalmers and Funeral Directors, and the Burial Association Board.

“(a) The Arkansas Cemetery Board, State Board of Embalmers and Funeral Directors, and Burial Association Board are abolished, and their powers, duties, functions, records, personnel, property, unexpended balances of appropriations, allocations, or other funds are transferred to the State Insurance Department by a type 3 transfer under § 25-2-106.

“(b)(1) For the purposes of this act, the State Insurance Department shall be considered a principal department established by Acts 1971, No. 38.

“(2) All rules promulgated by the Arkansas Cemetery Board, the State Board of Embalmers and Funeral Directors, and the Burial Association Board in effect before the effective date of this act [July 1, 2018], are transferred as a matter of law to the State Insurance Department on the effective date of this act [July 1, 2018] and shall be considered an officially promulgated rule of the State Board of Embalm-

ers, Funeral Directors, Cemeteries, and Burial Services of the State Insurance Department.”

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncoded sections of this act preceding the emergency clause titled ‘Funding and classification of cabinet-level department secretaries’ and ‘Transformation and Efficiencies Act transition team’ should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019.”

23-61-1101. Definitions.

As used in this subchapter:

(1) “Burial association” means:

(A) A person, firm, association, copartnership, corporation, company, or other organization that, from and after February 18, 1953:

(i) Undertakes for consideration paid by or on behalf of its members to defray all or a part of the funeral expenses of the members;

- (ii) Furnishes or undertakes to furnish merchandise, supplies, and services or any other character of burial benefits to the members; or
- (iii) Issues a certificate that provides for the payment of funeral benefits to the members in services, merchandise, or supplies, including the services of funeral directors and embalmers; and

(B) Every person, firm, association, copartnership, corporation, or company that, before February 18, 1953, has:

(i) Undertaken for a consideration to pay money to its contributors for the purpose of defraying all or part of the funeral expenses of a deceased person;

(ii) Furnished or has undertaken to furnish supplies and services or any other character of burial benefits to the contributing person or to his or her beneficiaries or members of his or her family; or

(iii) Issued any form of contract or certificate that, under its terms, provides for the payment of funeral benefits in money, services, or supplies, including the services of undertakers or embalmers;

(2) "Care and maintenance" means the continual maintenance of the cemetery grounds and graves in keeping with a properly maintained cemetery;

(3)(A) "Cemetery" means any land or structure in this state dedicated to and used or intended to be used for interment of human remains.

(B) "Cemetery" includes a:

(i) Burial park for earth interments;

(ii) Mausoleum for vault or crypt interments; or

(iii) Combination of one (1) or more burial parks for earth interments and mausoleums for vault or crypt interments;

(4) "Cemetery company" means an individual, partnership, corporation, limited liability company, or association owning or controlling cemetery lands or property and conducting the business of a cemetery or making an application with the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services to own or control the lands or conduct the business;

(5) "Permit holder" means a cemetery company that holds a permit issued by the board to own or operate a perpetual care cemetery; and

(6) "Perpetual care cemetery" means a cemetery for the benefit of which a permanent maintenance fund has been established in accordance with this subchapter.

History. Acts 2017, No. 788, § 3.

Effective Dates. Acts 2017, No. 788,
§ 2: July 1, 2018.

23-61-1102. Creation — Members.

(a) There is created within the State Insurance Department the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

(b) The members of the board shall be:

- (1) Residents of this state;
- (2) At least twenty-one (21) years of age; and
- (3) Of good moral character.

(c) The board shall be composed of nine (9) members as follows:

(1)(A) The Insurance Commissioner or his or her designated deputy.

(B) The commissioner or his or her designated deputy shall be a voting member of the board; and

(2)(A) Eight (8) members appointed by the Governor and subject to confirmation by the Senate who shall serve terms of five (5) years.

(B) Six (6) of the board members under subdivision (c)(2)(A) of this section shall include:

(i)(a) Two (2) licensed embalmers or funeral directors, each of whom has had at least five (5) consecutive years of experience as an embalmer or funeral directors in this state immediately preceding his or her appointment to the board.

(b) The Governor shall consult licensed embalmers and funeral directors before making an appointment under subdivision (c)(2)(B)(i)(a) of this section.

(c) The Arkansas Funeral Directors Association, Incorporated, or its successor shall submit to the Governor a list containing the names of at least four (4) professionals under subdivision (c)(2)(B)(i)(a) of this section;

(ii) Two (2) owners or operators of a licensed perpetual care cemetery in this state; and

(iii) Two (2) professionals engaged in the operation of a burial association for at least five (5) consecutive years preceding his or her appointment to the board.

(C)(i) The remaining two (2) members of the board shall be:

(a) One (1) person from this state, appointed at large, to represent the consumer community; and

(b) One (1) person from this state who is at least sixty (60) years of age, appointed at large, to represent the elderly community.

(ii) The members of the board under subdivision (c)(2)(C)(i) of this section shall not be actively engaged in or retired from the profession of embalming or funeral directing, the business of operating a burial association, or any other profession or occupation that is regulated by the board.

(iii) The members of the board under subdivision (c)(2)(C)(i) shall be full voting members of the board.

(d) The members of the board shall hold the first meeting within five (5) days after membership appointment and select one (1) member under subdivision (c)(2)(B) of this section as Chair of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services who shall serve a one-year term or until his or her successor is selected and qualified.

(e) Each congressional district shall be represented by membership on the board.

(f)(1) The length of the term for an initial member of the board under this section shall be staggered and set by the Governor.

(2) After the completion of the terms of the initial members of the board under subdivision (f)(1) of this section, a member of the board shall serve for a term of five (5) years, and shall serve on the board until a successor is appointed and qualified.

(3) A member of the board shall not be appointed to more than two (2) consecutive full terms.

(g) A vacancy on the board due to the death, resignation, or other cause of an appointed member of the board shall be filled by appointment by the Governor for the unexpired portion of the term in the same manner as required for an initial appointment.

(h) The presence of five (5) or more members of the board shall constitute a quorum.

(i) A member of the board who has a financial interest in a matter before the board shall be disqualified from:

(1) Participating in discussion pertaining to the matter; and

(2) Voting on the matter.

(j) A board member is eligible to receive expense reimbursement and stipends under § 25-16-901.

(k) The Governor may remove any member of the board for incompetence, improper conduct, gross neglect, or malfeasance.

(l)(1) Before entering upon duties of the board, members of the board shall take and subscribe to the oath prescribed by the Arkansas Constitution for state officers and shall file the subscribed oath in the office of the Secretary of State.

(2) The Secretary of State shall issue a certificate of appointment for the new member of the board.

(m) The board may make reimbursement of the necessary and reasonable travel, board, and lodging expenses of the board's employees, Executive Secretary of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services, and auditors incurred in the performance of their official duties.

History. Acts 2017, No. 788, § 3; 2019, No. 391, § 7.

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

Amendments. The 2019 amendment inserted "completion of the" near the beginning of (f)(2).

CASE NOTES

Recusal.

Member of the former State Board of Embalmers and Funeral Directors was not required to recuse or be removed from the board on the ground that he had resigned as county coroner because employment as a county coroner was not among the requirements for any board

position, and there was no evidence presented showing that the member was unqualified to serve on the board or biased against the funeral director. *Collins v. Ark. Bd. of Embalmers & Funeral Dirs.*, 2013 Ark. App. 678, 430 S.W.3d 213 (2013) (decision under former § 17-29-201).

23-61-1103. Powers and duties.

(a) The State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services may:

(1)(A) Hold a meeting no less than one (1) time each calendar quarter.

(B) The meeting shall be held at a time and place as the board or Insurance Commissioner may determine, after notice of such meeting has been given to the general public at least thirty (30) days before the meeting.

(C) The board shall meet upon written demand of any two (2) members of the board or upon the call of the commissioner;

(2) Make examinations required by § 17-29-301 et seq. available to applicants at least two (2) times annually at suitable locations during normal business hours;

(3) Promulgate appropriate rules:

(A) For the transaction of business of the board;

(B) For the betterment and promotion of the standards of service and practice;

(C) To establish the standards of practice and a code of ethics for persons licensed or authorized under this subchapter; § 17-29-301 et seq.; the Cemetery Act for Perpetually Maintained Cemeteries, § 20-17-1001 et seq.; or § 23-78-101 et seq.; and

(D) To establish qualifications necessary to:

(i) Practice the science of embalming;

(ii) Engage in the business of funeral directing;

(iii) Practice cremation;

(iv) Transport human remains; and

(v) Operate a funeral establishment, mortuary service, crematorium, retort, or transport service firm to transport human remains;

(4)(A) Develop, establish by rule, and administer a mandatory or voluntary continuing education program and its requirements for persons licensed or authorized by the board.

(B) The board may excuse licensees, as a group or as individuals, from a continuing education program, if any unusual circumstances, emergency, or hardship prevents participation in the program;

(5) Promulgate rules and publish forms to enforce and administer laws governing:

(A) Embalmers, funeral directors, and funeral establishments, under § 17-29-301 et seq.; § 17-29-401 et seq.; and § 17-29-501 et seq.;

(B) Burial associations under § 23-78-101 et seq.; and

(C) Cemetery companies under the Cemetery Act for Perpetually Maintained Cemeteries, § 20-17-1001 et seq.; and the Insolvent Cemetery Grant Fund Act, § 20-17-1301 et seq.;

(6) Suspend or revoke permits or licenses when a licensee fails to comply with any of the laws governing the licensee or when a licensee fails to comply with a rule or order of the board;

(7) Upon application, grant permits, licenses, or certificates of authority to applicants and licensees;

(8) When appropriate, amend permits, licenses, or certificates of authority;

(9)(A) Apply to Pulaski County Circuit Court to enjoin any act or practice and to enforce compliance with relevant laws and the rules and orders of the board when it appears that any person has engaged in or will engage in an act or practice that constitutes a violation of any provision of this subchapter or rule or order of the board.

(B) The court shall not require the board or commissioner to post a bond;

(10) Apply to Pulaski County Circuit Court or the circuit court in the county in which the licensee is located for the appointment of a receiver or conservator of the cemetery corporation or its permanent maintenance fund when it appears to the board or commissioner that a cemetery corporation is insolvent or that the cemetery corporation, its officers, directors, agents, or the trustees of its permanent maintenance fund, have violated this subchapter, relevant laws, or the rules or orders of the board;

(11)(A) Conduct hearings and subpoena witnesses, books, and records in connection with alleged violations of this subchapter, relevant laws, and the rules or orders of the board.

(B)(i) In case of contumacy or refusal to obey a subpoena issued to a person, the Pulaski County Circuit Court, upon application by the board, may issue to the person an order requiring him or her to appear before the board or the person designated by the board.

(ii) Failure to obey the order of the court may be punished by the court as a contempt of court.

(C) An order by the board under this subchapter shall be subject to review by the Pulaski County Circuit Court or by the circuit court of the county in which any part of the cemetery lies if an application for review of an order by the board is made within thirty (30) days of the date of the order; and

(12) Establish and collect reasonable fees.

(b) The board shall adopt bylaws and rules in connection with the care and disposition of human remains in this state.

(c)(1) The commissioner, in consultation with the Secretary of the Department of Commerce, may appoint assistants and deputies and examiners, inspectors, attorneys, clerks, stenographers, and other personnel as may be necessary to assist him or her in the discharge of the duties imposed upon him or her in overseeing the board.

(2) Personnel under subdivision (c)(1) of this section shall devote their entire business time to carrying out official duties concerning the board, or if appropriate, the State Insurance Department.

(d) The powers and authority under subsection (a) of this section shall not be in diminution or limitation of the powers and authority vested in the board by the various sections of this subchapter, but the board shall possess all powers and authority, whether set forth in this

section or not, to enable it to carry out the intent and purpose of this subchapter.

(e)(1) The board, when it shall deem necessary, shall be represented by the State Insurance Department.

(2)(A) If deemed necessary by the board, the board may employ special counsel whose services shall be paid for from funds of the board.

(B) Special counsel shall be retained only with the prior approval of the commissioner.

History. Acts 2017, No. 788, § 3; 2019, No. 910, § 604.

Effective Dates. Acts 2017, No. 788, § 2; July 1, 2018.

Amendments. The 2019 amendment

inserted “in consultation with the Secretary of the Department of Commerce” in (c)(1); and substituted “State Insurance Department” for “department” in (e)(1).

23-61-1104. Executive Secretary of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

(a)(1) The Insurance Commissioner, in consultation with the Secretary of the Department of Commerce, may appoint and employ a person as the Executive Secretary of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services who shall serve at the pleasure of the commissioner.

(2) The executive secretary shall devote the necessary time to the performance of his or her duties under this section.

(3) The duties of the executive secretary shall include:

(A) Collection of fees and charges under this subchapter; § 17-29-301 et seq.; the Cemetery Act for Perpetually Maintained Cemeteries, § 20-17-1001 et seq.; the Insolvent Cemetery Grant Fund Act, § 20-17-1301 et seq.; and § 23-78-101 et seq.;

(B) Keeping record of the proceedings of the board;

(C) Keeping an accurate account of all moneys received and disbursed by the commissioner; and

(D) Any other duties defined and designated by the board.

(b) The board shall maintain its main office location in Little Rock and transact the business of the board at the main office.

History. Acts 2017, No. 788, § 3; 2019, No. 910, § 605.

Effective Dates. Acts 2017, No. 788, § 2; July 1, 2018.

Amendments. The 2019 amendment inserted “in consultation with the Secretary of the Department of Commerce” in (a)(1).

23-61-1105. Embalmers and funeral directors.

(a) The Insurance Commissioner or a person appointed or employed by the commissioner shall:

(1) Have general supervision over field inspection and enforcement of this subchapter and § 17-29-301 et seq.;

(2) Make public the procedures for making inquiries into the practice of funeral directors or embalmers and for making complaints concerning the practices;

(3) Maintain a record of the licensee and business name and address of every person licensed under § 17-29-301 et seq., including the license number, date of the license, and the renewal date of the license;

(4) On request, supply a list of every person and funeral establishment licensed under § 17-29-301 et seq., to a person licensed as an embalmer or funeral director, to a common carrier in this state, to a hospital licensed in this state, or to any other person authorized by law to receive the list;

(5) Hold all moneys received by the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services to pay the necessary and allowable expenses for the operation of the board in carrying out the provisions of this subchapter; § 17-29-301 et seq.; the Cemetery Act for Perpetually Maintained Cemeteries, § 20-17-1001 et seq.; the Insolvent Cemetery Grant Fund Act, § 20-17-1301 et seq.; and § 23-78-101 et seq.;

(6) If applicable, receive and be paid an annual salary not to exceed the amount authorized by law; and

(7) Charge and collect a criminal background check processing fee in an amount necessary to recover the charge imposed by the Division of Arkansas State Police to conduct a criminal background check for a person applying for an initial license under § 17-29-301 et seq.

(b) The board may promulgate rules reasonably necessary to reflect any changes in the law as adopted by the United States Congress or any appropriate agency of the United States Government as it affects funeral establishments, funeral directors, or embalmers and for the purpose of keeping this law consistent with, and compatible to, the laws of the United States.

History. Acts 2017, No. 788, § 3.

Effective Dates. Acts 2017, No. 788,

§ 2: July 1, 2018.

23-61-1106. Inspector of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services — Funeral directing — Embalming, cremating, or transporting human remains.

(a)(1) The Insurance Commissioner may request that the Department of Commerce employ an agent or agents as Inspector of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services.

(2) A person is not eligible for appointment as inspector under subdivision (a)(1) of this section unless he or she has not fewer than five (5) consecutive years of active experience as an embalmer and funeral director licensed in this state.

(b) The inspector shall hold office at the pleasure of the commissioner, who shall determine his or her duties.

(c)(1) The inspector, with proper identification, may enter any office, premises, establishment, or place of business in this state where the practice of embalming, funeral directing, cremation, or transportation of human remains is carried on, or where the practice is advertised as being carried on, to:

(A) Inspect the office, premises, crematory, or establishment;

(B) Inspect the license and registration of a licensee;

(C) Inspect the manner and scope of training given to an apprentice; and

(D) Ensure compliance with all state laws and rules pertaining to funeral service.

(2) By accepting a license under § 17-29-301 et seq., the licensee grants permission for the inspector or other State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services designee to enter the licensee's business premises without prior notice.

(d) The inspector may serve and execute any process issued by a court under this subchapter, serve and execute any papers or process issued by the board under the authority of this subchapter and § 17-29-301 et seq., and perform such other duties as prescribed or ordered by the board.

(e) The inspector shall not accept any employment, salary, fees, or other remuneration from a funeral establishment or wholesale firm dealing in funeral supplies and equipment.

(f) The inspector shall receive such compensation as the board may determine within the maximum authorized by law.

History. Acts 2017, No. 788, § 3; 2019, No. 910, § 606.

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

Amendments. The 2019 amendment substituted "request that the Department of Commerce employ" for "appoint" in (a)(1).

23-61-1107. Crematoriums.

(a) The State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services may promulgate reasonable rules for the licensing of crematoriums.

(b) A crematorium shall not be operated in this state unless licensed by the board, and a dead human body shall not be cremated in this state except at a licensed crematorium.

(c) A violation of this section is a Class A misdemeanor.

History. Acts 2017, No. 788, § 3.

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

23-61-1108. Transportation of dead human bodies.

(a) In the interest of public health and to ensure the safe, secure, and timely transportation of dead human bodies in and through Arkansas, the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services may license, inspect, and promulgate reasonable rules for any person, partnership, corporation, association, society, or other legal entity engaged in the business of transporting dead human bodies over public streets and highways of this state.

(b)(1) A violation of the licensing and inspection requirements established by the board under this section is a Class A misdemeanor.

(2) A violation of rules promulgated by the board under this section is a Class A misdemeanor.

History. Acts 2017, No. 788, § 3; 2019, No. 391, § 8.

Amendments. The 2019 amendment added the (b)(1) and (b)(2) designations; added “the licensing and inspection requirements established by the board un-

der this section is a Class A misdemeanor” in (b)(1); and added “A violation of rules promulgated by the board under” in (b)(2).

Effective Dates. Acts 2017, No. 788, § 2; July 1, 2018.

23-61-1109. Cemeteries and cemetery companies.

(a) The State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services may:

(1)(A) Conduct periodic, special, or other examinations of a cemetery or cemetery company, including without limitation an examination of the physical condition or appearance of the cemetery, the financial condition of the cemetery company and any trust funds maintained by the cemetery company, and other examinations that the board or Insurance Commissioner deems necessary or appropriate in the public interest.

(B) An examination under subdivision (a)(1)(A) of this section shall be carried out by:

(i) A member or representative of the board;

(ii) A certified public accountant or registered public accountant as authorized under § 20-17-1007; or

(iii) The State Insurance Department;

(2) Issue or amend permits to operate a cemetery under this subchapter;

(3) Suspend or revoke permits to operate a cemetery when a cemetery fails to comply with this subchapter, rules promulgated under this subchapter, or any order of the board;

(4) Make rules and forms to enforce this subchapter;

(5) Require cemetery companies to observe minimum accounting principles and practices and make and keep the books and records for a period of time as the board may prescribe by rule;

(6) Require additional contributions to the permanent maintenance fund of the cemetery under this subchapter, including without limitation contributions not to exceed three thousand dollars (\$3,000) when-

ever a cemetery company fails to properly care for and maintain or preserve the cemetery;

(7) Apply to Pulaski County Circuit Court or the circuit court of the county in which the cemetery is located for appointment of a receiver or conservator of the cemetery company or its permanent maintenance fund when it appears to the board that a cemetery company is insolvent or that the cemetery company, its officers, directors, agents, or the trustees of its permanent maintenance fund, have violated this subchapter and the rules promulgated under this subchapter or have failed to comply with any board order;

(8) Increase by rule the amount of a deposit required under § 20-17-1016 if the board determines that a greater sum is necessary to assure that the permanent maintenance fund will earn sufficient income to provide for the care and maintenance of the cemetery; and

(9)(A) Purchase insolvent, licensed perpetual care cemeteries that have been in court-ordered receivership or conservatorship for at least five (5) years.

(B) If the taking of legal possession of the cemetery under subdivision (a)(9)(A) of this section requires the payment of consideration, any payment made by the board shall not exceed one thousand dollars (\$1,000).

(b) A violation of this section is a Class A misdemeanor.

History. Acts 2017, No. 788, § 3.

Effective Dates. Acts 2017, No. 788,

§ 2: July 1, 2018.

23-61-1110. Burial associations.

(a) The State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services may:

(1) Grant certificates of authority to burial associations;

(2) Revoke certificates of authority, charters, or other authority granted to burial associations in this state;

(3) Fix the minimum assessments or minimum membership dues for which burial associations may issue certificates for benefits in specified amounts;

(4) Supervise the affairs of all burial associations organized or operating in this state;

(5) Conduct hearings as provided in this subchapter and collect, receive, hold, and expend annual license fees under this subchapter and § 23-78-101 et seq.;

(6) Adopt and enforce such rules as the board deems necessary and expedient for the proper operation of the burial association and the carrying out of the objects and purposes of this subchapter;

(7) Establish actuarial rates and reserve requirements necessary to ensure the financial integrity of all burial associations;

(8) Approve requests from burial associations that have excess financial resources, as determined by the board, to adopt a plan to pay

death benefits in excess of the face value of a certificate of benefits issued by the burial association to members of the burial association; and

(9) Approve or disapprove an application for the dissolution, merger, or reorganization of a burial association organized and operating in this state.

(b) The board may determine issues between different burial associations and between burial associations and their respective members, and render binding decisions, subject to appeal.

History. Acts 2017, No. 788, § 3.

Effective Dates. Acts 2017, No. 788, § 2: July 1, 2018.

CASE NOTES

ANALYSIS

Jurisdiction.
Rules.

Jurisdiction.

Where mortuary and representatives of deceased members of burial association sued association on funeral expenses, jurisdiction was in circuit court not in burial association board as latter adjudicated disputes among associations and between association and its members only. *Hog-gard & Sons Enters., Inc. v. Russell Burial Ass'n*, 255 Ark. 576, 501 S.W.2d 613 (1973) (decision under prior law).

Rules.

An administrative agency's rules must implement the purpose of the legislation

pursuant to which they are made. *Arkansas Burial Ass'n Bd. v. McEuen Burial Ass'n*, 302 Ark. 133, 788 S.W.2d 234 (1990) (decision under prior law).

Amendment to rule 18 and new rules 38 and 39, of the Rules of the Arkansas Burial Association Board, were held invalid. *Arkansas Burial Ass'n Bd. v. McEuen Burial Ass'n*, 302 Ark. 133, 788 S.W.2d 234 (1990) (decision under prior law).

Cited: *McEuen Burial Ass'n v. Arkansas Burial Ass'n Bd.*, 298 Ark. 572, 769 S.W.2d 415 (1989) (decision under prior law).

23-61-1111. Duties of State Insurance Department.

(a) The State Insurance Department shall assist the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services in the performance of the duties of the board.

(b) Assistance under subsection (a) of this section shall include without limitation:

(1) Receiving and disseminating filings, questions, and requests on behalf of the board to the members of the board in advance of each meeting;

(2) Reviewing all filings, questions, and requests on behalf of the board and offering the department's opinion on the resolution of the matter;

(3) Issuing written responses regarding complaints received by the board;

(4) Scheduling all meetings in conjunction with the Chair of the State Board of Embalmers, Funeral Directors, Cemeteries, and Burial Services;

(5) Providing appropriate legal notices for all scheduled meetings;

(6) Establishing a site where meetings of the board may be held;

(7) When necessary, scheduling the services of a court reporter for all meetings of the board;

(8) Providing legal representation and assistance through the legal staff of the department to the board in matters pertaining to this subchapter;

(9) Acting as a liaison between the board and any court involved in the administration of any perpetual care cemetery placed in receivership;

(10) Performing inspections at burial associations, cemeteries, funeral homes, funeral establishments and crematoriums for which complaints have been received by the board;

(11) Performing special audits and examinations as necessary;

(12) Scheduling, performing, and assisting in performing regular audits and examinations of cemeteries, funeral homes, funeral establishments, and crematoriums;

(13) Administering or assisting in administering the annual reporting for all perpetual care cemeteries; and

(14) Assisting in the formulation of legislation on behalf of the board.

History. Acts 2017, No. 788, § 3.

Effective Dates. Acts 2017, No. 788,
§ 2: July 1, 2018.

CHAPTER 62

KINDS OF INSURANCE — REINSURANCE

SUBCHAPTER.

1. DEFINITIONS.
2. REINSURANCE GENERALLY.
3. ARKANSAS CREDIT FOR REINSURANCE LAW.
4. REINSURANCE INTERMEDIARY ACT.

SUBCHAPTER 1 — DEFINITIONS

SECTION.

- 23-62-105. Casualty insurance — Definition.
23-62-107. Marine insurance.

SECTION.

- 23-62-111. Employee benefit stop-loss insurance.

Effective Dates. Acts 2019, No. 698,
§ 4: "This act is effective for travel insurance sold on or after October 1, 2019."

23-62-101. Definitions not mutually exclusive.**CASE NOTES****Type of Policy.**

In insured's suit against an insurer for breach of contract and negligence based on the insurer's failure to give notice of policy expiration and to pay on a grain-loss claim, genuine issues of material fact remained whether the insurance policy at

issue could be both casualty insurance and property insurance, such that § 23-88-105 applied. Thus, summary judgment in favor of the insurer was not appropriate. *McClendon v. Farm Bureau Mut. Ins. Co.*, 2019 Ark. App. 216, 575 S.W.3d 432 (2019).

23-62-104. Property insurance.**CASE NOTES****Type of Insurance.**

In insured's suit against an insurer for breach of contract and negligence based on the insurer's failure to give notice of policy expiration and to pay on a grain-loss claim, genuine issues of material fact remained whether the insurance policy at issue could be both casualty insurance and property insurance, such that § 23-

88-105 applied, given the broad statutory language concerning property insurance and § 23-62-101, which provides that an insurance policy can fall under two or more types of insurance. Thus, summary judgment in favor of the insurer was not appropriate. *McClendon v. Farm Bureau Mut. Ins. Co.*, 2019 Ark. App. 216, 575 S.W.3d 432 (2019).

23-62-105. Casualty insurance — Definition.

(a) As used in the Arkansas Insurance Code, unless the context otherwise requires, "casualty insurance" includes:

(1) **VEHICLE INSURANCE.** Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability, or expense resulting from or incidental to ownership, maintenance, or use of the vehicle, aircraft, or animal, together with insurance against accidental death or accidental injury to individuals, including the named insured, while in, entering, alighting from, adjusting, repairing, cranking, or caused by being struck by a vehicle, aircraft, or draft or riding animal, if the insurance is issued as an incidental part of insurance on the vehicle, aircraft, or draft or riding animal;

(2) **LIABILITY INSURANCE.** Insurance against legal liability for the death, injury, or disability of any human being or for damage to property and the provision of medical, hospital, surgical, disability, or accident and health benefits to injured persons and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance;

(3) **WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY.** Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for death, disablement, or injury of employees;

(4) **BURGLARY AND THEFT.** Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation; or wrongful conversion, disposal, or concealment; or from any attempt at any of the foregoing; including supplemental coverage for medical, hospital, surgical, and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers and documents, resulting from any cause;

(5) **PERSONAL PROPERTY FLOATER.** Insurance upon personal effects against loss or damage from any cause under a personal property floater;

(6) **GLASS.** Insurance against loss or damage to glass, including its lettering, ornamentation, and fittings;

(7) **BOILER AND MACHINERY.** Insurance against any liability and loss or damage to property or interest therein resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery, and apparatus of any kind, whether or not insured;

(8) **LEAKAGE AND FIRE EXTINGUISHING EQUIPMENT.** Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus, water pipes or containers, or by water entering through leaks or openings in buildings and insurance against loss or damage to sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus;

(9) **CREDIT.** Insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured;

(10) **MALPRACTICE.** Insurance against legal liability of the insured and against loss, damage, or expense incidental to a claim of liability including medical, hospital, surgical, and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury, or disablement of any person or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary, or professional service. However, malpractice insurance shall not include abstractor's professional liability insurance;

(11) **LIVESTOCK.** Insurance against loss or damage to livestock and for services of a veterinarian for those animals;

(12) **ENTERTAINMENTS.** Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation thereof due to death, accidental injury, or sickness of performers, participants, directors, or other principals;

(13) **ELEVATOR.** Insurance against loss of or damage to any property of the insured resulting from the ownership, maintenance, or use of

elevators, escalators, and moving stairways, except loss or damage by fire, and to make inspection of and issue certificates of inspection upon elevators, escalators, and moving stairways;

(14) **ABSTRACTOR'S PROFESSIONAL LIABILITY.** Insurance against legal liability of the insured, and against loss, damage, or expense incidental to a claim of liability arising out of damage to the economic interest of any person as the result of negligence in rendering the professional service of an abstractor;

(15) **MORTGAGE LIEN PROTECTION.**

(A) Insurance issued at the time a loan is originated to indemnify a lender against loss from a borrower's misrepresentation or nondisclosure of an outstanding lien encumbering the borrower's property if the lender has no actual knowledge of the lien.

(B) Mortgage lien protection shall not be issued for:

(i) A transaction involving:

(a) A purchase money mortgage; or

(b) A transfer of title;

(ii) Coverage beyond the term of the loan;

(iii) Coverage for a diminution in value of secured property; or

(iv) Coverage in excess of two hundred fifty thousand dollars (\$250,000).

(C) The borrower's credit score shall not be used to determine the amount or cost of mortgage lien protection.

(D) Mortgage lien protection insurance shall not include any other insurance coverage that may be issued by a title insurer as defined in § 23-103-402; and

(16) **MISCELLANEOUS.** Insurance against any other kind of loss, damage, or liability properly a subject of insurance and not within any other kind of insurance as defined in this subchapter and §§ 23-62-201, 23-62-202, 23-62-204, 23-62-205, and 23-63-701 if that insurance is not disapproved by the Insurance Commissioner as being contrary to law or public policy.

(b) Provision of medical, hospital, surgical, and funeral benefits and of coverage against accidental death or injury as incidental to and part of other insurance as stated under subdivisions (a)(1), (2), (4), and (10) of this section shall for all purposes be deemed to be the same kind of insurance to which it is so incidental and shall not be subject to provisions of the Arkansas Insurance Code applicable to life insurance or accident and health insurance.

History. Acts 1959, No. 148, § 76; 1985, No. 744, § 2; A.S.A. 1947, § 66-2405; Acts 2001, No. 1603, §§ 4, 5; 2009, No. 210, § 1; 2017, No. 1082, § 1.

Amendments. The 2017 amendment substituted "two hundred fifty thousand dollars (\$250,000)" for "one hundred thousand dollars (\$100,000)" in (a)(15)(B)(iv).

CASE NOTES

Type of Policy.

In insured's suit against an insurer for breach of contract and negligence based on the insurer's failure to give notice of policy expiration and to pay on a grain-loss claim, genuine issues of material fact remained whether the insurance policy at issue could be both casualty insurance and property insurance, such that § 23-

88-105 applied, given the broad statutory language concerning property insurance and § 23-62-101, which provides that an insurance policy can fall under two or more types of insurance. Thus, summary judgment in favor of the insurer was not appropriate. *McClendon v. Farm Bureau Mut. Ins. Co.*, 2019 Ark. App. 216, 575 S.W.3d 432 (2019).

23-62-107. Marine insurance.

As used in the Arkansas Insurance Code, unless the context otherwise requires, "marine insurance" includes:

(1) Insurance against any and all kinds of loss or damage to:

(A) Vessels, craft, aircraft, cars, automobiles, and vehicles of every kind as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests, and all other kinds of property and interests therein, in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment or while awaiting shipment or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks;

(B) Person or property in connection with or appertaining to a marine, inland marine, transit, or transportation insurance, including liability for, loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of the insurance, but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance, or use of automobiles;

(C) Precious stones, jewels, jewelry, gold, silver, and other precious metals, whether used in business or trade or otherwise and whether they are in course of transportation or otherwise; and

(D) Bridges, tunnels, and other instrumentalities of transportation and communication, excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage, unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion are the only hazards to be covered; piers, wharves, docks and ships, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion; other aids to navigation and transportation, including dry docks and marine railways, against all risks;

(2) “Marine protection and indemnity insurance”, meaning insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for loss of or damage to the property of another person; and

(3) Travel insurance, as defined in § 23-64-234.

History. Acts 1959, No. 148, § 78; A.S.A. 1947, § 66-2407; Acts 2019, No. 698, § 1.

Effective Dates. Acts 2019, No. 698, § 4: “This act is effective for travel insurance sold on or after October 1, 2019.”

Amendments. The 2019 amendment added (3).

23-62-111. Employee benefit stop-loss insurance.

(a) As used in this subchapter, “employee benefit stop-loss insurance” means coverage that insures an employer or an employer-sponsored health plan against the risk that:

(1) One (1) claim will exceed a specific dollar amount; or

(2) The entire loss of a self-insurance plan will exceed a specific dollar amount.

(b) An insurer authorized to transact accident and health insurance business in this state may issue employee benefit stop-loss insurance in this state.

(c) An insurer shall not issue an employee benefit stop-loss insurance policy that:

(1) Has an annual attachment point for claims incurred per individual that is less than twenty thousand dollars (\$20,000);

(2) Has an annual aggregate attachment point for groups of fifty (50) or less that is lower than one hundred twenty percent (120%) of expected claims;

(3) Has an annual aggregate attachment point for groups of fifty-one (51) or more that is lower than one hundred ten percent (110%) of expected claims; or

(4) Provides for direct coverage of healthcare expenses of an individual.

(d) The Insurance Commissioner may adopt rules that carry out the requirements of this section, including without limitation rules that require:

(1) Additional standards for employee benefit stop-loss insurance policies; and

(2) Disclosures to policyholders by an insurance carrier providing employee benefit stop-loss insurance.

History. Acts 2007, No. 496, § 4; 2009, No. 726, § 10; 2011, No. 760, § 2; 2021, No. 383, § 1.

Amendments. The 2021 amendment

deleted “the greater of” following “lower than” in (c)(2), deleted (c)(2)(A) and (c)(2)(C), and removed the (c)(2)(B) designation; and made a stylistic change.

SUBCHAPTER 2 — REINSURANCE GENERALLY

SECTION.

23-62-203. Rules.

RESEARCH REFERENCES

ALR. Construction and Application of “Following Form” Clause in Reinsurance Contract. 22 A.L.R.7th Art. 3 (2017).

23-62-203. Rules.

The Insurance Commissioner may adopt reasonable rules to implement the provisions of this subchapter.

History. Acts 1995, No. 1272, § 24; deleted “and regulations” following “rules” in the section heading and in the text.

Amendments. The 2019 amendment

SUBCHAPTER 3 — ARKANSAS CREDIT FOR REINSURANCE LAW

SECTION.

23-62-305. Credit allowed a domestic ceding insurer — Definitions.

23-62-306. Asset or reduction from liability for reinsurance ceded by domestic insurer to assuming insurer — Non-compliant assuming insurer.

SECTION.

23-62-307. Qualified United States financial institutions.

23-62-308. Rules.

23-62-309. Applicability — Reinsurance agreements.

Effective Dates. Acts 2021, No. 672, § 5: July 1, 2021. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that the process for crediting an insurer for reinsurance is in need of clarification in this state; that simplifying the procedures to allow an insurer to apply for and receive credit for reinsurance will provide financial benefit to the citizens of

this state; and that this act is necessary because an insurer that is able to apply for and process a credit for reinsurance should pass those savings on to the citizens of this state. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2021.”

23-62-305. Credit allowed a domestic ceding insurer — Definitions.

(a)(1)(A) A domestic ceding insurer shall be allowed credit for reinsurance as an asset or a reduction from liability on account of

reinsurance ceded only when the reinsurer meets the requirements of subdivisions (a)(4) and (5) of this section and subsections (b)-(f) of this section.

(B) The Insurance Commissioner may adopt rules under § 23-62-308(b) to implement this section and specify additional requirements relating to:

- (i) The valuation of assets or reserve credits;
- (ii) The amount and forms of security supporting reinsurance arrangements as described in § 23-62-308(b); and
- (iii) The circumstances in which credit of a noncomplying assuming insurer shall be reduced or eliminated.

(2) Credit shall be allowed under subdivisions (a)(4) and (5) of this section or subsection (b) of this section only for cessions of the kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in:

(A) Its state of domicile; or

(B) In the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

(3) Credit shall be allowed under subsection (b) or subsection (c) of this section only if the applicable requirements of subsection (g) of this section have been satisfied.

(4) Credit shall be allowed if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(5)(A) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the Insurance Commissioner as a reinsurer in this state.

(B) To be eligible for accreditation by the Insurance Commissioner under this section, a reinsurer shall:

(i) File with the Insurance Commissioner evidence of its submission to this state's jurisdiction;

(ii) Submit to this state's authority to examine its books and records;

(iii) Be licensed to transact insurance or reinsurance in at least one (1) state, or, in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one (1) state;

(iv) File annually with the Insurance Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(v)(a) Demonstrate to the satisfaction of the Insurance Commissioner that the reinsurer has adequate financial capacity to meet the reinsurer's reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

(b) A reinsurer is considered to meet the requirements under subdivision (a)(5)(B)(v)(a) of this section if, at the time of application

to the Insurance Commissioner, the reinsurer maintains a surplus regarding policyholders in an amount not less than twenty million dollars (\$20,000,000) and whose accreditation has not been denied by the Insurance Commissioner within ninety (90) days of applying.

(b)(1) Credit shall be allowed if the reinsurance is ceded to an assuming insurer that is domiciled in, or, in the case of a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this subchapter and the assuming insurer or United States branch of an alien assuming insurer:

(A) Maintains a surplus regarding policyholders in an amount not less than twenty million dollars (\$20,000,000); and

(B) Submits to the authority of this state to examine its books and records.

(2) The requirement of subdivision (b)(1)(A) of this section does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c)(1)(A) Credit shall be allowed if the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in § 23-62-307(b), for the payment of the valid claims of its United States ceding insurers, their assigns, and their successors in interest.

(B) To enable the Insurance Commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the Insurance Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners annual statement form by licensed insurers.

(C) The assuming insurer shall submit to examination of its books and records by the Insurance Commissioner and bear the expense of examination.

(2) A credit for reinsurance shall not be granted under this section unless the form of the trust and any amendments to the trust have been approved by:

(A) The insurance commissioner of the state where the trust is domiciled; or

(B) The insurance commissioner of another state who, under the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(3)(A) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.

(B) The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States.

(C) The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns, and their successors in interest.

(D) The trust and the assuming insurer shall be subject to examination as determined by the Insurance Commissioner.

(4)(A) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(B) By February 28 of each year, the trustees of the trust shall:

(i) Report to the Insurance Commissioner in writing the balance of the trust;

(ii) List the trust's investments at the preceding year's end; and

(iii) Certify:

(a) The date of termination of the trust, if so planned; or

(b) That the trust will not expire before the following December 31.

(d) An assuming insurer is subject to the requirements, as applicable, for the following categories:

(1)(A) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers.

(B) Except as provided in subdivision (d)(2) of this section, the assuming insurer shall maintain a trustee surplus of at least twenty million dollars (\$20,000,000);

(2)(A) The commissioner with principal regulatory oversight of the trust may authorize a reduction in the assuming insurer's required trustee surplus if the Insurance Commissioner finds that:

(i) The assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) years; and

(ii) In light of reasonably foreseeable adverse loss development and based on an assessment of the risk, the assuming insurer's new required surplus level is adequate to protect United States ceding insurers, policyholders, and claimants.

(B)(i) The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows.

(ii) The risk assessment shall consider any applicable material risk factors, including without limitation:

(a) The lines of business involved;

(b) The stability of the incurred loss estimates; and

(c) The effect of the surplus requirements on the assuming insurer's liquidity or solvency.

(C) The minimum required trustee surplus shall not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust;

(3)(A) In the case of a group, including incorporated and individual unincorporated underwriters:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust shall consist of a trustee account in an amount not less

than the underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this act, the trust shall consist of a trustee account in an amount not less than the underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(iii) In addition to the trusts under this subdivision (d)(3)(A), the group shall maintain in trust a trustee surplus of which one hundred million dollars (\$100,000,000) shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(B) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(C) Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Insurance Commissioner:

(i) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(ii) If a certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the group; and

(4) In the case of a group of incorporated underwriters under common administration, the group shall:

(A) Have continuously transacted an insurance business outside the United States for at least three (3) years immediately before making application for accreditation;

(B) Maintain aggregate policyholders' surplus of at least ten billion dollars (\$10,000,000,000);

(C) Maintain a trust fund in an amount that is not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group under reinsurance contracts issued in the name of the group;

(D) Maintain a joint trustee surplus of which one hundred million dollars (\$100,000,000) shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and

(E) Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

(e)(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the Insurance Commis-

sioner as a reinsurer in this state and secures its obligations under the requirements of this section.

(2) In order to be eligible for certification, the assuming insurer shall:

(A) Be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Insurance Commissioner under subdivision (e)(4) of this section;

(B) Maintain minimum capital and surplus, or its equivalent, in an amount to be determined by rule adopted by the commissioner;

(C) Maintain financial strength ratings from at least two (2) rating agencies deemed acceptable as determined by rule adopted by the commissioner;

(D) Agree to:

(i) Submit to the jurisdiction of this state;

(ii) Appoint the Insurance Commissioner as its agent for service of process in this state;

(iii) Provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment; and

(iv) Meet any additional filing requirements as determined by rule adopted by the Insurance Commissioner concerning an initial application for certification and on an ongoing basis; and

(E) Satisfy any other requirements for certification deemed necessary by rule adopted by the Insurance Commissioner.

(3)(A) A certified reinsurer may be an association, including an incorporated underwriter and an individual unincorporated underwriter.

(B) In order to be eligible for certification, an association that meets the requirements in subdivision (e)(2) of this section shall:

(i) Satisfy the association's minimum capital and surplus requirements through the capital and surplus equivalents or net of liabilities of the association and the association's members, including a joint central fund that may be applied to any unsatisfied obligation of the association or any of the association's members, in an amount determined by the Insurance Commissioner to provide adequate protection;

(ii) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(iii) Within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Insurance Commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member, or if a certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the association.

(4)(A) The Insurance Commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer that is licensed and domiciled in the jurisdictions is eligible to be considered for certification by the commissioner as a certified reinsurer.

(B) In order to determine whether or not the domiciliary jurisdiction of an assuming insurer that is not in the United States is eligible to be recognized as a qualified jurisdiction, the Insurance Commissioner shall:

(i) Evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis; and

(ii) Consider the rights, benefits, and the extent of reciprocal recognition afforded by the foreign jurisdiction to reinsurers licensed and domiciled in the United States.

(C) A qualified jurisdiction shall agree to share information and cooperate with the Insurance Commissioner with respect to all certified reinsurers domiciled within that jurisdiction.

(D) A jurisdiction shall not be recognized as a qualified jurisdiction if the Insurance Commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

(E) Additional factors may be considered in the discretion of the Insurance Commissioner.

(5)(A) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners committee process.

(B) The Insurance Commissioner shall consider this list in determining qualified jurisdictions.

(C) If the Insurance Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Insurance Commissioner shall provide thoroughly documented justification according to criteria to be developed by promulgation of rules by the Insurance Commissioner.

(D) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program shall be recognized as qualified jurisdictions.

(E) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Insurance Commissioner has the discretion to suspend the reinsurer's certification indefinitely, instead of revoking the certification.

(6)(A) The Insurance Commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the Insurance Commissioner.

(B) The Insurance Commissioner shall publish a list of all certified reinsurers and their ratings.

(7)(A) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this section at a level consistent

with its rating, as determined in rules promulgated by the Insurance Commissioner.

(B) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Insurance Commissioner and consistent with § 23-62-306 or, in the case of a multibeneficiary trust, according to subsection (c) of this section.

(C)(i) If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection (c) of this section and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this section.

(ii) The certified reinsurer shall agree that the certified reinsurer has bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each of the trust accounts, to fund, upon termination of any of the trust accounts, out of the remaining surplus of the trust any deficiency of any other of the trust accounts.

(D) The minimum trustee surplus requirements under subsection (d) of this section are not applicable to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this section, except that the trust shall maintain a minimum trustee surplus of ten million dollars (\$10,000,000).

(E) For obligations incurred by a certified reinsurer under this section, if the security is insufficient, the Insurance Commissioner shall reduce the allowable credit by an amount proportionate to the deficiency and may impose further reductions in allowable credit if the commissioner finds a material risk of nonpayment of the certified reinsurer's obligations when due.

(F)(i) For purposes of this section, a certified reinsurer whose certification is terminated shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations.

(ii) As used in subdivision (e)(7)(F)(i) of this section, "terminated" means revocation, suspension, voluntary surrender, and inactive status.

(iii) If the Insurance Commissioner continues to assign a higher rating under this section to a certified reinsurer, the requirement to secure one hundred percent (100%) of a certified reinsurer's obligations if certification is terminated does not apply to a certified reinsurer in inactive status or to a reinsurer under a suspended certification.

(8) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners accredited jurisdiction, the Insurance Commissioner may defer to that jurisdiction's

certification and to the assigned rating, and then the assuming insurer shall be considered a certified reinsurer in this state.

(9)(A) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status to continue to qualify for a reduction in security for its in-force business.

(B) An inactive certified reinsurer shall continue to comply with the requirements of this section.

(C) The Insurance Commissioner shall assign a rating that accounts for the reasons the reinsurer does not assume new business in this state.

(f)(1)(A) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that:

(i) Either:

(a) Has a head officer in a reciprocal jurisdiction; or

(b) Is domiciled in a reciprocal jurisdiction, as applicable; and

(ii) Is licensed in a reciprocal jurisdiction.

(B) As used in subdivision (f)(1)(A) of this section, “reciprocal jurisdiction” means a jurisdiction that:

(i)(a) Is a foreign jurisdiction outside the United States that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member of the European Union.

(b) As used in subdivision (f)(1)(B)(i)(a) of this section, “covered agreement” means an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, as it existed on January 1, 2021, that addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(ii) Is a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program; or

(iii) Is a qualified jurisdiction, as determined by the Insurance Commissioner under subdivision (f)(2)(B) of this section, that:

(a) Is not otherwise described in subdivision (f)(1)(A)(i) or subdivision (f)(1)(A)(ii) of this section; and

(b) Meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the Insurance Commissioner by rule.

(C) An assuming insurer shall have and maintain on an ongoing basis:

(i) A minimum solvency or capital ratio, as applicable, that is established by rule;

(ii) The minimum capital and surplus, or its equivalent, calculated according to the methodology of the jurisdiction of the assuming insurer, in an amount to be stated by rule;

(iii) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, the minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts determined by the Insurance Commissioner through rule; and

(iv) If an assuming insurer is an association, including incorporated and individual unincorporated underwriters, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(D) An assuming insurer shall agree and provide adequate assurance to the commissioner, in a form specified by the commissioner pursuant to rule, to provide:

(i) A prompt written notice and explanation to the Insurance Commissioner if the assuming insurer falls below the minimum requirements stated in this subsection or if any regulatory action is taken against it for serious noncompliance with applicable law;

(ii)(a) A statement of consent in writing to the jurisdiction of the courts of this state and to the appointment of the Insurance Commissioner as agent for service of process.

(b) The Insurance Commissioner may require that consent for service of process be provided to the Insurance Commissioner and be included in each reinsurance agreement.

(c) This subdivision (f)(1)(D)(ii) does not limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent these agreements are unenforceable under applicable insolvency or delinquency laws;

(iii) A statement of consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(iv) A statement that each reinsurance agreement shall include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate;

(v) A statement of confirmation that the assuming insurer is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers; and

(vi)(a) An agreement to notify the ceding insurer and the Insurance Commissioner and to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities to the

ceding insurer should the assuming insurer enter into such a solvent scheme of arrangement.

(b) A security described in subdivision (f)(1)(D)(vi)(a) of this section shall be in a form consistent with subsection (e) of this section, § 23-62-306, and as specified by the Insurance Commissioner by rule.

(E) An assuming insurer or its legal successor shall provide, if requested by the Insurance Commissioner, on behalf of the assuming insurer and any legal predecessors, certain documentation to the Insurance Commissioner, as specified by the Insurance Commissioner by rule.

(F) An assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria stated by the Insurance Commissioner by rule.

(G) An assuming insurer's supervisory authority shall confirm to the commissioner on an annual basis, as of the preceding December 31, or at the annual date otherwise reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements stated in subdivisions (f)(1)(C)(i)-(iv) of this section.

(H) This subsection does not preclude an assuming insurer from providing the commissioner with information on a voluntary basis.

(2)(A) The Insurance Commissioner shall timely create and publish a list of reciprocal jurisdictions.

(B)(i) The Insurance Commissioner's list as described in subdivision (f)(2)(A) of this section shall require the Insurance Commissioner to:

(a) Include any reciprocal jurisdiction as defined in subdivisions (f)(1)(B)(i) and (ii) of this section; and

(b) Consider other reciprocal jurisdictions that are included on the list of reciprocal jurisdictions published through the National Association of Insurance Commissioners.

(ii) The Insurance Commissioner may approve a reciprocal jurisdiction that does not appear on the National Association of Insurance Commissioners list of reciprocal jurisdictions according to criteria adopted by the Insurance Commissioner by rule.

(C)(i) The Insurance Commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, according to a process adopted by rule of the Insurance Commissioner, except that the Insurance Commissioner shall not remove from the list a reciprocal jurisdiction as defined in subdivisions (f)(1)(B)(i) and (ii) of this section.

(ii) Upon removal of a reciprocal jurisdiction from the list described in subdivision (f)(2)(A) of this section, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed according to this subchapter.

(iii) The Insurance Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions stated in

this subsection and to which cessions shall be granted credit according to this subsection.

(iv) The Insurance Commissioner may add an assuming insurer to the list described in subdivision (f)(2)(C)(iii) of this section if a National Association of Insurance Commissioners accredited jurisdiction has added the assuming insurer to a list of assuming insurers or if, upon initial eligibility, the assuming insurer:

(a) Submits the information to the Insurance Commissioner as required under subdivision (f)(1) of this section; and

(b) Complies with any additional requirements that the Insurance Commissioner may impose by rule, except to the extent that the additional requirements conflict with an applicable covered agreement.

(3)(A) If the Insurance Commissioner determines that an assuming insurer no longer meets one (1) or more of the requirements under subdivision (f)(1) of this section, the Insurance Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under subdivision (f)(1) of this section according to the Insurance Commissioner by rule.

(B) While an assuming insurer's eligibility is suspended, a reinsurance agreement issued, amended, or renewed after the effective date of the suspension shall not qualify for credit except to the extent that the assuming insurer's obligations under the contract are secured according to § 23-62-306.

(C) If an assuming insurer's eligibility is revoked, credit for reinsurance shall not be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Insurance Commissioner and consistent with § 23-62-306.

(D) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(E) This section does not limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this subchapter or other applicable law or rule.

(F) Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after July 1, 2021, and only with respect to losses incurred and reserves reported on or after the later of:

(i) The date on which the assuming insurer has met all eligibility requirements under subdivision (f)(1) of this section; and

(ii) The effective date of the new reinsurance agreement, amendment, or renewal.

(4) This section does not:

(A) Alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under subdivision (f)(3)(F) of this section, as long as the reinsurance qualifies for credit under any other applicable provision of this subchapter;

(B) Allow an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement; or

(C) Limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of this section but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law, rule, or regulation of that jurisdiction.

(g)(1) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by subsections (b)-(d) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(A) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall:

(i) Submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(ii) Comply with all requirements necessary to give the court jurisdiction; and

(iii) Abide by the final decision of the court or of any appellate court in the event of an appeal; and

(B) To designate the Insurance Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(2) This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if the obligation is created in the agreement.

(h) If the assuming insurer does not meet the requirements of subsection (a), subsection (b), subsection (c), subsection (d), subsection (e), or subsection (f) of this section, the assuming insurer shall not be allowed a credit unless the assuming insurer agrees in the trust agreements to the following conditions:

(1) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subdivision (d)(3) of this section or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the

laws of its state or country of domicile, then the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all of the assets of the trust fund;

(2) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight according to the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(3) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part of the trust fund are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or a part of the assets shall be returned by the insurance commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(4) The grantor shall waive any right otherwise available to it under any law of the United States that is inconsistent with this subsection.

(i)(1) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Insurance Commissioner may suspend or revoke the reinsurer's accreditation or certification after notice and an opportunity for a hearing.

(2) The suspension or revocation shall not take effect until after the Insurance Commissioner's order on hearing unless:

(A) The reinsurer waives the right to a hearing; and

(B) The Insurance Commissioner's order is based on:

(i) Regulatory action by the reinsurer's domiciliary jurisdiction;

(ii) The voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subdivision (e)(8) of this section; or

(iii) A finding by the commissioner of an emergency that requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(3) While a reinsurer's accreditation or certification is suspended, a reinsurance contract issued or renewed after the effective date of the suspension shall not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured under § 23-62-306.

(4) If a reinsurer's accreditation or certification is revoked, credit for reinsurance shall not be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured under subdivision (e)(7) of this section or § 23-62-306.

(j)(1)(A) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business.

(B) A domestic ceding insurer shall notify the Insurance Commissioner within thirty (30) days after reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers

exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders or after it is determined that reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers is likely to exceed this limit.

(C) The notification shall demonstrate to the Insurance Commissioner that the exposure is safely managed by the domestic ceding insurer.

(2)(A) A ceding insurer shall take steps to diversify its reinsurance program.

(B) A domestic ceding insurer shall notify the Insurance Commissioner within thirty (30) days after ceding to any single assuming insurer or group of affiliated assuming insurers more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year or after it has determined that the reinsurance ceded to any single assuming insurer or group of affiliated assuming insurers is likely to exceed this limit.

(C) The notification shall demonstrate to the Insurance Commissioner that the exposure is safely managed by the domestic ceding insurer.

History. Acts 1977, No. 790, § 5; A.S.A. 1947, § 66-2415; Acts 1991, No. 723, § 12; 1995, No. 1272, § 7; 2005, No. 506, § 13; 2015, No. 1223, § 1; 2021, No. 672, § 1.

Amendments. The 2021 amendment added (a)(1)(B) and redesignated (a)(1) as (a)(1)(A); inserted "subdivisions (a)(4) and (5) of this section and subsections (b)-(f) of" in (a)(1)(A); redesignated (b) and (c) as (a)(4) and (a)(5), and redesignated (d)-(l)

as (b)-(j); rewrote (f); rewrote the introductory language of (h); added "and" at the end of (i)(2)(A); updated internal references; and made stylistic changes.

U.S. Code. For provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act related to covered agreements, see 31 U.S.C. §§ 313, 314. For provisions of the act related to reinsurance, see 15 U.S.C. § 8221 et seq.

23-62-306. Asset or reduction from liability for reinsurance ceded by domestic insurer to assuming insurer — Noncompliant assuming insurer.

(a)(1) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of § 23-62-305 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(2) The Insurance Commissioner shall promulgate rules necessary to implement this section that address:

(A) The valuation of assets or reserve credits;

(B) The amount and forms of security supporting reinsurance arrangements as described in § 23-62-308(b); and

(C) The circumstances in which credit of a noncomplying assuming insurer shall be reduced or eliminated.

(b) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held:

(1) In the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(2) In the case of a trust, in a qualified United States financial institution as defined in § 23-62-307(b).

(c) The security may be in the form of:

(1) Cash;

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(3)(A) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution as defined in § 23-62-307(a), effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement.

(B) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, shall continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

(4) Any other form of security acceptable to the Insurance Commissioner.

History. Acts 1991, No. 723, § 13; 2005, No. 506, § 14; 2015, No. 1223, § 2; 2021, No. 672, § 2.

Amendments. The 2021 amendment added (a)(2) and redesignated former (a) as (a)(1).

23-62-307. Qualified United States financial institutions.

(a) For purposes of § 23-62-306(c)(3), a “qualified United States financial institution” means an institution that:

(1) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;

(2) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the Insurance Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(b) A “qualified United States financial institution” means, for purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(1) Is organized, or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the

United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(2) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

History. Acts 1991, No. 723, § 13;
2015, No. 1223, § 3.

23-62-308. Rules.

(a) The Insurance Commissioner may adopt rules implementing this subchapter.

(b) The Insurance Commissioner may adopt rules:

(1) Applicable to a reinsurance arrangement that relates to:

(A) A life insurance policy with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(B) A universal life insurance policy with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(C) A variable annuity with guaranteed death or living benefits;

(D) A long-term care insurance policy; or

(E) A life or health insurance or annuity product for which the National Association of Insurance Commissioners adopts model regulatory requirements with respect to credit for reinsurance;

(2) Applicable to a rule adopted under this section that may apply to a treaty containing:

(A) A policy issued on or after January 1, 2015; or

(B) A policy issued before January 1, 2015, if risk pertaining to the policy is ceded in connection with the treaty on or after January 1, 2015; and

(3) That require a ceding insurer to calculate the amounts or forms of security according to rules promulgated by the Insurance Commissioner.

(c) A rule adopted under this section shall not apply to cessions of an assuming insurer:

(1) That:

(A) Meets the conditions in § 23-62-305(f);

(B) Is certified in this state; or

(C) Maintains at least two hundred fifty million dollars (\$250,000,000) in capital and surplus as determined according to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, as it existed on January 1, 2021, and as adopted by the Insurance Commissioner by rule, excluding the impact of any permitted or prescribed practice; and

(2) That is licensed in at least:

(A) Twenty-six (26) states; or

(B) Ten (10) states, and licensed or accredited in a total of thirty-five (35) states.

(d) This section does not limit the general authority of the Insurance Commissioner to promulgate rules.

History. Acts 1991, No. 723, § 14; added (b) through (d), and designated the 2015, No. 1223, § 4; 2021, No. 672, § 3. former section as (a).
Amendments. The 2021 amendment

RESEARCH REFERENCES

ALR. Who May Enforce Liability of Reinsurer. 87 A.L.R.6th 319.

23-62-309. Applicability — Reinsurance agreements.

This subchapter applies to a cession of a reinsurance agreement if that reinsurance agreement has an inception, anniversary, or renewal date not less than six (6) months after July 1, 2021.

History. Acts 2015, No. 1223, § 5; “Sections 23-62-305 — 23-62-307 apply” 2021, No. 672, § 4. and “July 1, 2021” for “July 22, 2015”; and

Amendments. The 2021 amendment made a stylistic change. substituted “This subchapter applies” for

SUBCHAPTER 4 — REINSURANCE INTERMEDIARY ACT

SECTION.

23-62-413. Rules.

23-62-408. Required contract provisions — Reinsurance intermediary managers.

RESEARCH REFERENCES

ALR. Who May Enforce Liability of Reinsurer. 87 A.L.R.6th 319.

23-62-409. Prohibited acts.

RESEARCH REFERENCES

ALR. Who May Enforce Liability of Reinsurer. 87 A.L.R.6th 319.

23-62-413. Rules.

The Insurance Commissioner may adopt reasonable rules for the implementation and administration of the provisions of this subchapter.

History. Acts 1993, No. 527, § 1; 2019, No. 315, § 2626. deleted “and regulations” following “rules” in the section heading and in the text.

Amendments. The 2019 amendment

CHAPTER 63

INSURANCE COMPANIES GENERALLY

SUBCHAPTER.

1. GENERAL PROVISIONS.
2. AUTHORITY TO DO BUSINESS.
5. INSURANCE HOLDING COMPANY REGULATORY ACT.
6. FINANCIAL REPORTING STANDARDS.
8. INVESTMENTS.
12. ANNUAL REPORTS BY PROPERTY AND CASUALTY INSURERS. [REPEALED.]
13. RISK-BASED CAPITAL ACT.
14. DISCLOSURE OF MATERIAL TRANSACTIONS ACT.
16. LICENSING AND REGULATION OF CAPTIVE INSURERS.
17. PROTECTED CELL COMPANY ACT.
18. AUDITS OF MEDICAL PROVIDERS.
20. CORPORATE GOVERNANCE ANNUAL DISCLOSURE ACT.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

23-63-107. Prompt processing of payment
by insurer.

SECTION.

23-63-116. Retaliatory tax credit.

23-63-107. Prompt processing of payment by insurer.

(a) An insurer shall not intentionally or unreasonably delay, for more than three (3) business days after presentment for collection, the processing of any properly executed and endorsed check, draft, or electronic funds transfer issued in settlement of an insurance claim.

(b) It is the intent of the General Assembly that an insured or a claimant be paid the insured's or the claimant's settlement proceeds at the earliest possible time.

(c) Any insurer violating this section shall pay the insured or the claimant a penalty of two hundred dollars (\$200) or fifteen percent (15%) of the face amount of the check, draft, or electronic funds transfer, whichever is higher.

History. Acts 1983, No. 477, § 3; A.S.A. 1947, § 66-2018; Acts 2021, No. 367, § 10.

Amendments. The 2021 amendment inserted "or electronic funds transfer" in (a) and (c); substituted "an insured or a

claimant be paid the insured's or the claimant's" for "insureds or claimants shall be paid their" in (b); and made stylistic changes.

23-63-116. Retaliatory tax credit.

(a) A domestic property and casualty insurer that pays any other state or foreign country a tax, fine, penalty, deposit requirement or other material requirement, or any other fee that is determined by the Insurance Commissioner to be a retaliatory tax is entitled to a reduction or credit upon its gross premiums tax in the same amount paid to the other state or foreign country.

(b) This section does not apply to any of the following imposed by another state:

(1) An application fee, examination fee, license fee, appointment fee, or a continuation fee for an agent, adjuster, service representative, or consultant of a domestic property and casualty insurer; or

(2) An ad valorem tax on real or personal property or special purpose obligations, fees, or assessments.

History. Acts 2015, No. 1223, § 6.

SUBCHAPTER 2 — AUTHORITY TO DO BUSINESS

SECTION.

23-63-201. Certificate of authority required — Exceptions.

23-63-216. Annual statement and other information.

SECTION.

23-63-218. Change of domicile.

23-63-201. Certificate of authority required — Exceptions.

(a) No person shall act as an insurer and no insurer shall transact insurance in this state unless authorized by a subsisting certificate of authority issued to it by the Insurance Commissioner except as to such transactions as are expressly otherwise provided for in the Arkansas Insurance Code.

(b) A certificate of authority shall not be required of an insurer with respect to the following:

(1) Investigation, settlement, or litigation of claims under its policies lawfully written in Arkansas, or making change of beneficiary or other modifications of an insurance or annuity contract, or otherwise administering insurance or annuity contracts in force, or liquidation of assets and liabilities of the insurer, other than collection of new premiums, all as resulting from its former authorized operations in Arkansas;

(2) Transactions subsequent to issuance of or relative to a policy covering only subjects of insurance not resident, located, or expressly to be performed in Arkansas at time of issuance, or covering property in course of transportation by land, air, or water to, from, or through Arkansas and including any preparation or storage incidental thereto, and lawfully solicited, written, or delivered outside Arkansas; or

(3) Transactions pursuant to surplus lines coverages lawfully written under § 23-65-101 et seq., the Unauthorized Insurers Process Act, § 23-65-201 et seq., and the Surplus Lines Insurance Law, § 23-65-301 et seq., of the Arkansas Insurance Code.

(c) A foreign insurer may transact business in this state without certificate of authority, for the purpose and to the extent only of investing its funds in Arkansas real estate or securities, by complying with the laws of this state relating to foreign business corporations in general. Such an insurer shall not be subject to any other provisions of the Arkansas Insurance Code.

(d)(1)(A) The commissioner, in his or her reasonable discretion guided by the standards contained in this subsection and consistent with the purposes set forth in this subsection, may issue a special permit to make fixed-dollar life-only annuity agreements with donors to any duly organized domestic or foreign nonstock corporation or association conducted without profit and:

(i) Engaged in active operation for at least five (5) years prior to receiving the permit solely in bona fide charitable, religious, missionary, educational, or philanthropic activities; or

(ii) Not engaged in active operation solely in bona fide charitable, religious, missionary, educational, or philanthropic activities for five (5) years if the commissioner is reasonably satisfied that:

(a) The entity is affiliated with a corporation or association that meets the requirements of subdivision (d)(1)(A)(i) of this section; and

(b) An adequate level of management expertise is readily available to the entity requesting the permit.

(B) The permit authorizes the corporation or association to receive gifts of money or other assets of monetary value that the commissioner may authorize for its agreement to pay an annuity to the donor or the donor's nominee and to carry out the annuity agreement.

(C) Before making an annuity agreement under this subsection, every corporation or association shall file with the commissioner for his or her approval either:

(i) A schedule of its maximum annuity rates that shall be computed on the basis of the annuity standard adopted by it for calculating its reserves; or

(ii) A statement certifying that it adopts and will adhere to the annuity rates as published from time to time by the American Council on Gift Annuities or its successor until the corporation or association advises the commissioner to the contrary in writing and files a schedule of its new proposed maximum annuity rates for approval.

(D) Filings and approvals required under this subsection shall be subject to the provisions of §§ 23-79-109 and 23-79-110.

(2) Upon entering an annuity agreement, a domestic corporation or association shall establish and maintain liabilities with respect to the annuity by one (1) of the following methods, using an amount:

(A) Not less than the present value of future benefits payable to the donor as determined by the most recent method established by the Internal Revenue Service;

(B) Determined by applying the method established for annuities under the Standard Valuation Law for Life Insurance and Annuities, § 23-84-101 et seq.; or

(C) Equal to the aggregate values determined at the dates of contribution of all assets received from donors with respect to annuities for annuitants who are then living.

(3)(A) Unless otherwise permitted by the commissioner, each corporation or association shall maintain a segregated account or accounts for its charitable gift annuities.

(B) The segregated account or accounts shall be used solely to pay the charitable gift annuity obligations of the corporation or association.

(C) If the commissioner finds the reserve established by a permittee inadequate at any time, the commissioner shall order the permittee to increase its reserve accordingly, or the commissioner may stipulate the reserving method for the permittee to rectify the reserve deficiency.

(4) Each corporation or association, except those identified in subdivision (d)(5) of this section, shall maintain net admitted assets at least equal to the greater of:

(A) The sum of its reserves on its outstanding agreements, all other liabilities, and a surplus of at least ten percent (10%) of the reserves; or

(B) The amount of fifty thousand dollars (\$50,000).

(5) Each domestic corporation or association maintaining reserves in the manner described in subdivision (d)(2)(C) of this section shall maintain net admitted assets at least equal to the amount of the reserves plus all other outstanding liabilities.

(6) In determining reserves, a deduction shall be made for all or any portion of an annuity risk that is reinsured by a life insurance company authorized to do business in this state.

(7) The required admitted assets shall be invested:

(A) Only in securities permitted by §§ 23-63-801 — 23-63-833, 23-63-835, 23-63-836, 23-63-839, and 23-63-840; or

(B) In accordance with the prudent investor rule stated in §§ 24-2-610 — 24-2-619.

(8) No corporation or association organized under the laws of another state shall be permitted to make annuity agreements in this state unless it complies with all requirements of this subsection imposed upon domestic corporations or associations, except that a corporation or association organized under the laws of another state may invest its reserves and surplus funds in securities permitted by the laws of its state of domicile.

(9)(A) No corporation or association shall make or issue in this state any annuity contract before obtaining a permit issued in accordance with the provisions of this subsection.

(B) If after notice and hearing the commissioner finds that a corporation or association having a permit has failed to comply with the requirements of this subsection, the commissioner may revoke or suspend the permit or order the permittee to cease making new annuity contracts until it complies.

(C)(i) All corporations or associations operating under this subsection shall file an annual financial statement of their operations and accounts and schedule of outstanding annuities with applicable reserves within one hundred eighty (180) days of the end of their fiscal year.

(ii) The report shall be prepared by a certified public accountant in accordance with generally accepted accounting principles detailing

the financial condition and status of the corporation or association as of the conclusion of its most recent fiscal year.

(iii) Each domestic corporation or association investing assets in the manner described in subdivision (d)(7)(B) of this section shall file with the annual report:

(a) A description of the organization's investment philosophy for charitable gift annuities and how the investments of the company are designed to meet future charitable gift annuity obligations;

(b) A report from the organization identifying the members of the investment committee charged with making investment decisions regarding charitable gift annuity assets, including a description of each committee member's investment expertise; and

(c) A certification of the board of directors of the corporation or association that attests that its investments and investment transactions match the organization's philosophy and meet the standards of the prudent investor rule stated in §§ 24-2-610 — 24-2-619.

(10) The commissioner may promulgate any rules and regulations the commissioner considers necessary or desirable to implement the provisions of this subsection.

(e)(1) The commissioner shall promulgate rules to allow a city, town, municipality, or county of this state acting independently or in any combination pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., to obtain a charitable annuity permit for the purpose of establishing a charitable annuity program.

(2)(A) The charitable annuity program shall permit any person or an entity to make voluntary and charitable donations to benefit the bona fide charitable, educational, and philanthropic programs, including without limitation libraries, museums, and governmentally owned hospitals, of a city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq.

(B) The charitable donation may be made to assist the establishment or maintenance of streets, parks, children's playgrounds, libraries, museums, beautification projects, or any other charitable, educational, or philanthropic purpose of a city, town, municipality, or county.

(3) The charitable annuity permit shall authorize the city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., to receive unconditional gifts of money and property and to receive gifts of money and property conditioned upon paying an annuity to the donor or the donor's nominee.

(4) The rules of the commissioner to implement this subsection shall provide without limitation:

(A) That the city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., has been actively involved in

the operation of the public charitable, educational, or philanthropic activity for at least five (5) years prior to the issuance of the permit;

(B) For the investment of the assets and maintenance of the liabilities and surplus of the charitable annuity program appropriate to funding the annuities;

(C) That separate accounts be maintained solely for the benefit of annuity contract owners;

(D) The prior approval of annuity contract forms and annuity rates by the commissioner; and

(E) Annual financial reporting of a charitable annuity program of a city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., that has been granted a charitable annuity permit under this subsection.

(f) The commissioner may punish a person that fails to meet the requirements of subsection (d) or subsection (e) of this section by:

(1) Imposing a penalty of up to ten thousand dollars (\$10,000); or

(2) Suspending or revoking the charitable annuity permit and authority to operate under subsection (d) or subsection (e) of this section.

History. Acts 1959, No. 148, §§ 43-45; § 1; 2005, No. 905, § 1; 2007, No. 496, A.S.A. 1947, §§ 66-2201 — 66-2203; Acts § 8; 2009, No. 726, §§ 12 – 16; 2013, No. 1993, No. 1147, § 1806; 2003, No. 1099, 355, § 3.

23-63-216. Annual statement and other information.

(a)(1) Annually on or before March 1 or within an extension of time that the Insurance Commissioner for good cause may have granted, each authorized insurer shall file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the December 31 preceding.

(2) The statement shall be the appropriate and most recent National Association of Insurance Commissioners':

(A) "Annual Statement Blank For Life And Accident And Health";

(B) "Property And Casualty Annual Statement Blank";

(C) "Title Insurance Annual Statement Blank";

(D) "Annual Statement Blank for Health" for use by hospital, medical, and dental service or indemnity corporations;

(E) "Fraternal Annual Statement Blank";

(F) "Annual Statement Blank for Health" for health insurers or health maintenance organizations and others; or

(G) Other National Association of Insurance Commissioners' convention blank as appropriate.

(3) The statement shall be prepared in accordance with the most recent and appropriate companion National Association of Insurance Commissioners' "Annual and Quarterly Statement Instructions" and follow those accounting practices and procedures prescribed by the most recent and appropriate companion National Association of Insurance Commissioners' Accounting Practices and Procedures Manual.

(4) Arkansas domestic insurers shall file the statement with the commissioner in hard-copy format.

(5) Each authorized insurer shall file an audited financial statement on or before June 1 of each year.

(6) Authorized foreign and alien insurers complying with subsection (b) of this section are deemed to have satisfied the requirement to file the statement with the commissioner.

(7) The commissioner may allow a life insurer or property and casualty insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of its total premium considerations or total statutory required reserves, respectively, to file the "Annual Statement Blank for Health" as its annual statement with the companion quarterly statement forms.

(8)(A) The National Association of Insurance Commissioners' annual statement convention blank shall be verified by the oath of the insurer's president or vice president and secretary, treasurer, or actuary, as applicable, or if a reciprocal insurer, by its attorney in fact or if a corporation, its like officers.

(B)(i) The statement of an alien insurer shall be verified by the oath of the insurer's United States manager or other officer authorized and shall relate only to its transactions and affairs in the United States unless the commissioner requires otherwise.

(ii) If the commissioner requires a statement as to the alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible.

(C) The commissioner may waive a requirement under this section for verification under oath.

(9)(A) The commissioner may refuse to continue the insurer's certificate of authority, as provided in § 23-63-211, or may suspend or revoke the certificate of authority of an insurer failing to file its annual statement when due.

(B)(i) In addition, the insurer shall be subject to a penalty of one hundred dollars (\$100) for each day of delinquency.

(ii) The penalty shall be collected by the commissioner, if necessary, by a civil suit brought by the commissioner in Pulaski County Circuit Court, unless the penalty is waived by the commissioner upon a showing by the insurer of good cause for its failure to file its report on or before the date due.

(10) At the time of filing, the insurer shall pay the fee for filing its annual statement as prescribed by § 23-61-401.

(11) In addition to information called for and furnished in connection with its annual statement, an insurer shall furnish to the commissioner as soon as reasonably possible such information with respect to its transactions or affairs as the commissioner requests in writing.

(12)(A) In accordance with the specifications applicable to annual financial statements, each authorized domestic insurer and health maintenance organization and hospital or medical service corpora-

tion, or other domestic licensee so directed by the State Insurance Department in writing shall also file with the commissioner a quarterly financial statement on a form prescribed by the commissioner not later than forty-five (45) days following the end of each of the first three (3) calendar quarters of each year, excepting the fourth quarter of each calendar year, that shall be reconciled in the annual financial statement.

(B) The filing specifications of this section for annual financial reports apply to quarterly financial reports.

(b)(1)(A) Except as provided in subdivision (b)(1)(B) of this section, in addition to the information required by subsection (a) of this section, an authorized insurer reporting fifty thousand dollars (\$50,000) or more in annual gross premiums shall file for each line of business written in this state a market conduct annual statement, or successor product, in the general form and context, in the time frame required by, and according to instructions provided by the National Association of Insurance Commissioners.

(B) An authorized insurer that reports any volume of annual gross premiums collected in long-term care annuity hybrid, long-term care life hybrid, or long-term care stand-alone lines of business written in this state shall file for each line of business written in Arkansas a market conduct annual statement, or successor product, in the general form and context, in the time frame required by, and according to instructions provided by the National Association of Insurance Commissioners.

(C) If a particular line of business does not have an approved market conduct annual statement form, the authorized insurer is not required to file a report for that line of business until such time as the National Association of Insurance Commissioners adopts a market conduct annual statement form for that line of business.

(2) An insurer is not required to file a market conduct annual statement under subdivision (b)(1) of this section if the insurer:

(A) Sells prepaid funeral or prepaid legal products only; or

(B) Is licensed only in this state.

(3) The commissioner may, for good cause, grant an extension of time for filing a market conduct annual statement, if a written application for an extension of time is received at least five (5) business days before the filing due date.

(c)(1) Insurers shall submit the market conduct annual statement data required by subsection (b) of this section in an electronic format and manner as prescribed by the commissioner. The commissioner may designate the National Association of Insurance Commissioners to receive the market conduct annual statement on his or her behalf, for the purpose of collecting, compiling, aggregating, and reporting on market conduct annual statement data.

(2) Any forms or data submitted by the insurer as market conduct annual statement data under this subsection are deemed to be documents or information obtained from the insurer by the department as

examination under § 23-61-207 without the necessity of a formal examination notice under § 23-61-203 or examination report and adoption order under § 23-61-205.

(d)(1)(A) Annually on or before March 1, each domestic, foreign, and alien insurer authorized to transact business in this state shall file with the National Association of Insurance Commissioners a copy of its annual statement convention blank, along with such additional filings as prescribed by the commissioner as of the December 31 preceding.

(B) The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification.

(C) Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners.

(2) Foreign insurers that are domiciled in a state with a law substantially similar to this subsection and comply with their state's law are in compliance with this subsection.

(3) In the absence of malice, members of the National Association of Insurance Commissioners, their committees, subcommittees, task forces, delegates, employees, and others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the commissioner under the authority of this subsection and shall not be subject to civil liability for libel, slander, or another cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required in this section.

(4) The commissioner may impose the sanctions set out in subdivision (a)(9) of this section on an insurer failing to file its annual statement with the National Association of Insurance Commissioners when due or within an extension of time that the commissioner for good cause has granted.

(5) Each authorized insurer shall submit its annual and quarterly statement and supplemental information to the National Association of Insurance Commissioners in electronic format as specified by the National Association of Insurance Commissioners.

(e)(1) Each domestic insurer authorized to transact business in this state shall include in its annual statement an opinion, as is relevant to the lines of business the domestic insurer is authorized to write, on its life and health policy and claim reserves and its property and liability loss and loss adjustment expense reserves by a qualified actuary.

(2) The opinion shall be in the format prescribed by the National Association of Insurance Commissioners' Annual and Quarterly Statement Instruction handbook.

(f)(1) An insurer or a related entity licensed to do business in this state shall maintain the insurer's or the related entity's books, records,

and documents in a manner that allows the commissioner to readily ascertain during an examination the insurer's or the related entity's compliance with the insurance laws of this state, rules, and the standards outlined in the most recent and appropriate companion National Association of Insurance Commissioners' Market Conduct Examiners Handbook, including without limitation company operations and management, policyholder service, marketing, producer licensing, underwriting, rating, complaint handling, grievance handling, and claims practices.

(2) A health insurer or a related entity shall maintain the health insurer's or the related entity's books, records, and documents in a manner that allows the commissioner to readily ascertain during a market conduct examination the health insurer's or the related entity's practices regarding network adequacy, utilization review, quality assessment and improvement, and provider credentialing.

(3) The records described under subdivisions (f)(1) and (2) of this section shall be retained for the current year plus five (5) calendar years.

History. Acts 1959, No. 148, § 62; 1973, No. 35, § 1; A.S.A. 1947, § 66-2220; Acts 1991, No. 723, §§ 17, 18; 1993, No. 527, §§ 2, 3; 1995, No. 1272, § 12; 1999, No. 301, § 1; 2001, No. 1604, §§ 26-28; 2005, No. 506, § 18; 2009, No. 726, § 18; 2011, No. 760, § 3; 2011, No. 1034, § 1; 2013, No. 355, §§ 4, 5; 2015, No. 1223, § 7; 2017, No. 283, § 8; 2019, No. 521, § 4; 2019, No. 696, § 1; 2021, No. 371, § 1.

Amendments. The 2017 amendment inserted "Except as provided under subdivision (b)(2) of this section" in (b)(1); substituted "fifty thousand dollars (\$50,000)"

for "seven million dollars (\$7,000,000)" in (b)(1)(A), (b)(1)(B), and the introductory language of (b)(1)(C); and added (b)(2) and redesignated former (b)(2) as (b)(3).

The 2019 amendment by No. 521 rewrote (b)(1) and (b)(3).

The 2019 amendment by No. 696 added (f).

The 2021 amendment substituted "Except as provided in subdivision (b)(1)(B) of this section, in addition to" for "In addition to" in (b)(1)(A); and inserted (b)(1)(B) and redesignated former (b)(1)(B) as (b)(1)(C).

23-63-218. Change of domicile.

(a) Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. The domestic insurer will be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state. An insurer which changes its status from foreign to domestic shall have all the rights, titles, and interests in the assets of the original corporation, as well as all of its liabilities and obligations. The insurer shall be recognized as an insurer formed under the laws of this state as of the date of its incorporation in its original domiciliary state.

(b)(1) Any domestic insurer may, upon the approval of the Insurance Commissioner, transfer its domicile to any other state in which it is

admitted to transact the business of insurance. Upon the transfer, the insurer shall cease to be a domestic insurer and shall be admitted to this state if qualified as a foreign insurer.

(2) The commissioner shall approve any proposed transfer unless he or she shall determine that the transfer is not in the interest of the policyholders of this state.

(c)(1) The certificate of authority, agents, appointments and licenses, rates, and other items which the commissioner allows, in his or her discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon the transfer if the insurer remains qualified to transact the business of insurance in this state.

(2) All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner.

(3) Every transferring insurer shall file new policy forms with the commissioner on or before the effective date of the transfer but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the commissioner.

(4) However, every transferring insurer shall notify the commissioner of the details of the proposed transfer and shall file promptly the resulting amendments to corporate documents filed or required to be filed with the commissioner.

(d) The commissioner may promulgate rules to carry out the purposes of this section.

History. Acts 1981, No. 820, §§ 1-4; A.S.A. 1947, §§ 66-2228 — 66-2231; Acts 1991, No. 1123, § 19; 2019, No. 315, § 2627.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in (d).

SUBCHAPTER 5 — INSURANCE HOLDING COMPANY REGULATORY ACT

SECTION.

23-63-503. Definitions.

23-63-506. Control of or merger with domestic insurer — Filing requirements — Definition.

23-63-508. Control of or merger with domestic insurer — Content of statement.

23-63-510. Control of or merger with domestic insurer — Approval by commissioner — Hearing.

SECTION.

23-63-514. Registration of insurers.

23-63-515. Standards — Definition.

23-63-516. Examination.

23-63-517. Confidential treatment.

23-63-518. Rules.

23-63-520. Voting of securities.

23-63-521. Injunctions.

23-63-531. Supervisory colleges.

23-63-532. Group-wide supervision of internationally active insurance groups.

23-63-503. Definitions.

As used in this subchapter:

(1) "Affiliate" of or person "affiliated" with a specific person means a person that directly or indirectly through one (1) or more intermediaries controls, is controlled by, or is under common control with the person specified;

(2)(A) "Control" or "controlling" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person unless the power is due to an official position or corporate office:

- (i) Through the ownership of voting securities;
- (ii) By contract other than a commercial contract for goods or nonmanagement services; or
- (iii) Otherwise.

(B)(i) Control is presumed to exist if a person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of another person.

(ii) This presumption may be rebutted by a showing that control does not exist in fact.

(C) After furnishing notice to the persons and the opportunity to be heard, the Insurance Commissioner may determine that control exists in fact, notwithstanding the absence of a presumption to that effect;

(3)(A) "Enterprise risk" means any activity, circumstance, event, or series of events involving at least one (1) affiliate of an insurer that, if not remedied, are likely to have a material adverse effect on the financial condition or liquidity of the insurer or the insurer's insurance holding company as a whole.

(B) "Enterprise risk" includes without limitation any action that may cause:

(i) An insurer's risk-based capital to fall into company action level under:

- (a) The Risk-Based Capital Act, § 23-63-1301 et seq.; and
- (b) Section 23-63-1501 et seq.; or

(ii) An insurer to be in a hazardous financial condition under State Insurance Department Rule 53;

(4) "Group-wide supervisor" means a regulatory official authorized to conduct and coordinate group-wide supervision activities who is acknowledged by the commissioner under § 23-63-532 to have sufficient and significant contacts with the internationally active insurance group;

(5) An "insurance holding company system" consists of two (2) or more affiliated persons, one (1) or more of which is an insurer. However, for purposes of this subchapter, the term shall not be deemed to include a domestic insurer or domestic holding company system authorized and doing business solely in this state and which is not affiliated with a foreign or alien insurer;

(6) "Insurer" means the same as defined in § 23-60-102, but "insurer" does not include:

(A) Agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(B) Fraternal benefit societies; or

(C) Nonprofit hospital and medical service corporations;

(7) "Internationally active insurance group" means an insurance holding company system that:

(A) Includes at least one (1) insurer registered under § 23-63-514;

(B) Has premiums written in at least three (3) countries;

(C) Has a percentage of gross premiums written outside the United States of at least ten percent (10%) of the insurance holding company system's total gross written premiums; and

(D) Based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars (\$50,000,000,000) or the total gross written premiums of the insurance holding company system are at least ten billion dollars (\$10,000,000,000);

(8)(A) "Person" includes a corporation, partnership, association, joint-stock company, business trust, unincorporated organization, depository corporation, a similar entity, or a combination of these entities acting in concert.

(B) "Person" does not include a securities broker performing no more than the usual and customary broker's function.

(C) "Person" includes an individual as that term is used in § 23-63-506;

(9) "Security holder" means a person who owns a security of a named person, including:

(A) Common stock;

(B) Preferred stock;

(C) Debt obligations; and

(D) Any other security convertible into or evidencing the right to acquire these securities;

(10) "Subsidiary" means an affiliate of a named person controlled by the person through one (1) or more intermediaries; and

(11) "Voting security" includes a security convertible into or evidencing a right to acquire a voting security.

History. Acts 1971, No. 288, § 3; 1975, 2009, No. 164, § 15; 2011, No. 887, § 1; No. 729, § 4; A.S.A. 1947, § 66-5003; Acts 2013, No. 355, § 6; 2015, No. 1223, § 8. 1991, No. 723, § 20; 2005, No. 506, § 20;

23-63-506. Control of or merger with domestic insurer — Filing requirements — Definition.

(a)(1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the

consummation thereof, the person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the insurer.

(2) No person shall enter into an agreement to merge with or otherwise acquire control of a domestic insurer or any person controlling a domestic insurer unless at the time the offer, request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved:

(A) The person has filed with the Insurance Commissioner and has sent to the insurer a statement containing the information required by this section and §§ 23-63-507 — 23-63-513; and

(B) The offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner prescribed in this section and §§ 23-63-507 — 23-63-513.

(b)(1) For purposes of this section, any person controlling a domestic insurer seeking to divest its controlling interest in the domestic insurer in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty (30) days prior to the cessation of control.

(2) The commissioner shall determine those instances in which the person seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction.

(c)(1) For the purposes of this section and §§ 23-63-507 — 23-63-513, a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. However, the person shall file a preacquisition notification with the commissioner containing the information set forth in § 23-63-527(b), sixty (60) days prior to the proposed effective date of the acquisition. Failure to file is subject to § 23-63-529(c).

(2) As used in this section, “person” shall not include any securities broker holding, in the usual and customary brokers’ function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

History. Acts 1971, No. 288, § 5; A.S.A. 1947, § 66-5005; Acts 1991, No. 723, § 21; 2001, No. 1604, § 33; 2005, No. 506, § 21; 2017, No. 386, § 1.

Amendments. The 2017 amendment added (b)(1) and (b)(2); and redesignated former (b)(1) and (b)(2) as (c)(1) and (c)(2).

23-63-508. Control of or merger with domestic insurer — Content of statement.

(a) The statement to be filed with the Insurance Commissioner pursuant to this section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in § 23-63-506 is to be effected, hereinafter called "acquiring party", and:

(A) If the person is an individual, his or her principal occupation and all offices and positions held during the past five (5) years and any conviction of crimes other than minor traffic violations during the past ten (10) years; and

(B) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the person and any predecessors thereof shall have been in existence, an informative description of the business intended to be done by the person and the person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to the positions. The list shall include for each individual the information required by subdivision (a)(1)(A) of this section;

(2) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing the consideration. However, where a source of the consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing the statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party, or for such lesser period as the acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in § 23-63-506 which each acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement, or acquisition referred to in § 23-63-506, and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in § 23-63-506 which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to in § 23-63-506 in which any acquiring party is involved, including, but not limited to, transfer of any of the securities, joint ventures, loans or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of

proxies. The description shall identify the persons with whom the contracts, arrangements, or understandings have been entered into;

(8) A description of the purchase of any security referred to in § 23-63-506 during the twelve (12) calendar months preceding the filing of the statement by any acquiring party, including the dates to purchase, names of the purchasers, and consideration paid or agreed to be paid therefor;

(9) A description of any recommendations to purchase any security referred to in § 23-63-506 made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of the acquiring party;

(10) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in § 23-63-506 and, if distributed, of additional soliciting material relating thereto;

(11) The terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of securities referred to in § 23-63-506 for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto;

(12) An agreement by the person required to file the statement referred to in § 23-63-506 that it will provide the annual report specified in § 23-63-514(m) for as long as control exists;

(13) An acknowledgement by the person required to file the statement referred to in § 23-63-506 that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(14) Such additional information as the commissioner may, by rule or regulation, prescribe as necessary or appropriate for the protection of policyholders and security holders of the insurer or in the public interest.

(b)(1) If the person required to file the statement referred to in § 23-63-506 is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by subdivisions (a)(1)-(14) of this section shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member.

(2) If any partner, member, or person is a corporation or the person required to file the statement referred to in § 23-63-506 is a corporation, the commissioner may require that the information called for by subdivisions (a)(1)-(14) of this section shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

(c) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant

to §§ 23-63-506 — 23-63-513, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two (2) business days after the person learns of the change. The insurer shall send the amendment to its stockholders.

History. Acts 1971, No. 288, § 5; A.S.A. 1947, § 66-5005; Acts 1991, No. 723, § 22; 2017, No. 386, § 2.

Amendments. The 2017 amendment added present (a)(12) and (a)(13).

23-63-510. Control of or merger with domestic insurer — Approval by commissioner — Hearing.

(a) The Insurance Commissioner shall approve any merger or other acquisition of control referred to in § 23-63-506 unless, after a public hearing thereon, he or she finds that:

(1) After change of control, the domestic insurer referred to in § 23-63-506 would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(2) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein;

(3) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders or the interests of any remaining security holders who are unaffiliated with the acquiring party;

(4) The terms of the offer, request, invitation, agreement, or acquisition referred to in § 23-63-506 are unfair and unreasonable to the security holders of the insurer;

(5) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets, or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management are unfair and unreasonable to policyholders of the insurer and not in the public interest; or

(6) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control.

(b)(1) The public hearing referred to in subsection (a) of this section shall be held within thirty (30) days after the statement required by § 23-63-506 is filed, and at least twenty (20) days' notice of the hearing shall be given by the commissioner to the person filing the statement.

(2) Not less than seven (7) days' notice of the public hearing shall be given by the person filing the statement to the insurer and to the other persons as may be designated by the commissioner.

(3)(A) The commissioner shall make a determination within the sixty-day period preceding the effective date of the proposed transaction.

(B) In connection with the change in control of the insurer, any determination by the commissioner that the person acquiring control of a domestic insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and rules of this state shall be made not later than sixty (60) calendar days after the date of notification of the change in control submitted pursuant to § 23-63-506(b).

(4) At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected thereby shall have the right to present evidence, examine, and cross-examine witnesses, and offer oral and written arguments and, in connection therewith, shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the courts of this state.

(5) All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

History. Acts 1971, No. 288, § 5; A.S.A. 1947, § 66-5005; Acts 1993, No. 901, § 10; substituted “rules” for “regulations” in 2001, No. 1604, § 34; 2019, No. 315, § 2628. **Amendments.** The 2019 amendment substituted “rules” for “regulations” in (b)(3)(B).

23-63-514. Registration of insurers.

(a) **REGISTRATION.** Every insurer that is authorized to do business in this state and that is a member of an insurance holding company system shall register with the Insurance Commissioner, except:

(1) A foreign insurer subject to disclosure requirements and standards adopted by code, statute, or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section; and

(2) A domestic insurer or a domestic holding company system authorized and doing business solely within this state that:

(A) Is not affiliated with a foreign or alien insurer; and

(B) Reported less than seven million dollars (\$7,000,000) in gross premium during the most recent annual reporting period.

(b) **INFORMATION AND FORM REQUIRED.** Every insurer subject to registration shall file a registration statement on a form prescribed by the National Association of Insurance Commissioners, which shall contain current information about:

(1) The capital structure, general financial condition, and ownership and management of the insurer and any person controlling the insurer;

(2) The identity of every member of the insurance holding company system;

(3) The following agreements in force, relationships subsisting, and transactions currently outstanding between the insurer and its affiliates:

(A) Loans, other investments, purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

- (B) Purchases, sales, or exchanges of assets;
 - (C) Transactions not in the ordinary course of business;
 - (D) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;
 - (E) All management and service contracts and all cost-sharing arrangements;
 - (F) Reinsurance agreements covering all or substantially all of one
- (1) or more lines of insurance of the ceding company;
- (G) Dividends and other distributions to shareholders; and
 - (H) Consolidated tax allocation agreements;
- (4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;
- (5)(A)(i) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates.
- (ii) Financial statements may include without limitation annual audited financial statements filed with the United States Securities and Exchange Commission pursuant to the Securities Act of 1933, 15 U.S.C. § 77a et seq., as it existed on January 1, 2017, or the Securities Exchange Act of 1934, 15 U.S.C. § 78a et seq., as it existed on January 1, 2017.
- (B) An insurer required to file financial statements pursuant to this section may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the United States Securities and Exchange Commission;
- (6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner; and
- (7) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.
- (c) MATERIALITY.
- (1) No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans, or extensions of credit, or investments, involving one-half of one percent (0.5%) or less of an insurer's admitted assets as of the December 31 next-preceding shall not be deemed material for purposes of this section.
- (2)(A) However, each registered insurer shall disclose in writing to the commissioner within five (5) business days following the decla-

ration of a dividend and no less than ten (10) business days prior to the payment of the dividend, all ordinary dividends payable to shareholders.

(B) The disclosure shall also be included in the reporting insurer's next annual and restated insurance registration statement and upon any statutory filing required under § 23-63-514 or § 23-63-515.

(d) AMENDMENTS TO REGISTRATION STATEMENTS.

(1)(A) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within fifteen (15) days after the end of the month in which it learns of each material change or addition.

(B) However, subject to § 23-63-515(c), each registered insurer shall report all dividends and other distributions to shareholders within five (5) business days following the declaration and no less than ten (10) business days prior to the payment of the dividend or other distribution.

(2) Registered insurers shall annually refile an amended and restated registration statement in the manner and at the times prescribed by the commissioner.

(e) TERMINATION OF REGISTRATION. The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(f) CONSOLIDATED FILING. The commissioner may require or allow two (2) or more affiliated insurers subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(g) ALTERNATIVE REGISTRATION. The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) of this section and to file all information and material required to be filed under this section.

(h) EXEMPTIONS. The provisions of this section shall not apply to any insurer, information, or transaction if, and to the extent that, the commissioner by rule or order shall exempt it from the provisions of this section.

(i) DISCLAIMER.

(1) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or the disclaimer may be filed by the insurer or any member of an insurance holding company system.

(2) The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation.

(3) After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with the person unless and until the commissioner disallows the disclaimer.

(4) The commissioner shall disallow a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

(j) **INFORMATION OF INSURERS.** Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, when such information is reasonably necessary to enable the insurer to comply with the provisions of this subchapter.

(k) **VIOLATIONS.** The failure to file a registration statement or any amendment thereto required by this section within the time specified for the filing shall be a violation of this section.

(l) **APPLICABILITY.** This section applies to domestic and foreign insurers or insurance holding company systems consistent with the definitions in § 23-63-503.

(m) **ENTERPRISE RISK FILING.** The ultimate controlling person of an insurer registered under this section, to the best of the ultimate controlling person's knowledge and belief, shall file an annual enterprise risk report that:

(1) Identifies the material risks within the insurance holding company system that may pose an enterprise risk to the insurer; and

(2) Is filed with the insurance commissioner of the lead state of the insurance holding company system as determined by the Financial Analysis Handbook, as adopted by the National Association of Insurance Commissioners.

History. Acts 1971, No. 288, § 6; A.S.A. 1947, § 66-5006; Acts 1989, No. 772, § 2; 1991, No. 723, § 23; 1999, No. 454, § 1; 2005, No. 506, § 22; 2007, No. 496, § 9; 2011, No. 887, §§ 3, 4; 2015, No. 1223, § 9; 2017, No. 386, § 3; 2019, No. 315, §§ 2629, 2630.

Amendments. The 2017 amendment inserted (b)(5) and added (b)(7).

The 2019 amendment deleted "regulation" following "rule" in the second sentence of (c)(1) and in (h).

23-63-515. Standards — Definition.

(a)(1) Material transactions by insurers registered with the Insurance Commissioner under § 23-63-514 with their affiliates shall be subject to the following standards:

(A) The terms shall be fair and reasonable;

(B) The books, accounts, and records of every party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties;

(C) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs;

(D) The charges or fees for services performed shall be reasonable;

(E) The expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied; and

(F) The commissioner by rule may establish additional requirements for a cost-sharing service agreement or a management agreement.

(2)(A) A domestic insurer subject to this subchapter and a person in its holding company system may not enter into a transaction, as described in subdivision (a)(2)(B) of this section, unless the insurer notifies the commissioner in writing of its intention at least thirty (30) days before, or less, as the commissioner may permit, and the commissioner does not disapprove of the transaction within such a period.

(B) A transaction that requires prior notice to the commissioner by a domestic insurer includes:

(i) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments, provided the transactions are equal to or exceed as of December 31 next-preceding:

(a) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and

(b) With respect to life insurers, three percent (3%) of the insurer's admitted assets;

(ii) Loans or extensions of credit to any person who is not an affiliate when the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in any affiliate of the insurer making the loans or extensions of credit, provided that the transactions are equal to or exceed as of December 31 next-preceding:

(a) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and

(b) With respect to life insurers, three percent (3%) of the insurer's admitted assets;

(iii) Reinsurance agreements or modifications thereto, including:

(a) All reinsurance pooling agreements; and

(b) Agreements in which the reinsurance premium, a change in the insurer's liabilities, any projected reinsurance premium, or a change in the insurer's liabilities in any of the next three (3) years equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of December 31 next-preceding, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one (1) or more affiliates of the insurer;

(iv) All management agreements, service contracts, tax allocation agreements, and all cost-sharing arrangements;

(v) Any material transactions specified by regulation that the commissioner determines may adversely affect the interests of the insurer's policyholders; and

(vi)(a) Any amendment or modification of an affiliate agreement that is subject to the materiality standards under subdivision (a)(1) of this section, including the reason for the amendment or modification and the financial impact on the domestic insurer.

(b) A domestic insurer shall notify the commissioner within thirty (30) days after a termination of a previously filed agreement in a format that is acceptable to the commissioner, to determine if further reporting or filing is required.

(3) A domestic insurer subject to this subchapter may not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the threshold amount and thus avoid the review that would otherwise occur. If the commissioner determines that those separate transactions were entered into over any twelve-month period for such a purpose, the commissioner may exercise his or her authority under § 23-63-522.

(4) In reviewing transactions pursuant to subdivision (a)(2) of this section, the commissioner shall consider whether the transactions comply with the standards set forth in subdivision (a)(1) of this section and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of a domestic insurer subject to this subchapter in any one (1) corporation if the total investment in such a corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

(b) For purposes of this subchapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among the several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification, and liquidity of the insurer's investment portfolio;

(7) The recent, past, and projected future trend in the size of the insurer's surplus as regards policyholders;

(8) The surplus as regards policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves; and

(10) The quality and liquidity of investments in subsidiaries made pursuant to § 23-63-505. The commissioner may treat any investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his or her judgment the investment so warrants.

(c) No insurer subject to registration under § 23-63-514 shall pay any extraordinary dividend or make any other extraordinary distribution to its stockholders until:

(1) Thirty (30) days after the commissioner has received notice of the declaration thereof and within that period has not disapproved the payment; or

(2) The commissioner shall have approved the payment within the thirty-day period.

(d)(1) As used in this section, "extraordinary dividend or distribution" means any dividend or distribution of cash or other property whose fair market value, together with that of the other dividends or distributions made within the preceding twelve (12) months, exceeds the greater of:

(A) Ten percent (10%) of the insurer's surplus with regard to policyholders as of the December 31 preceding the payment of the dividend or distribution; or

(B) The net gain from operations of the insurer if the insurer is a life insurer or the net income if the insurer is not a life insurer not including realized capital gains for the twelve-month period ending on the preceding December 31 but shall not include pro rata distributions of any class of the insurer's own securities.

(2)(A) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as a dividend.

(B) The carry forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediately preceding calendar years.

(e) Notwithstanding any other provisions of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration shall confer no rights upon stockholders until:

(1) The commissioner has approved the payment of the dividend or distribution; or

(2) The commissioner has not disapproved the payment within the thirty-day period referred to in subsection (c) of this section.

(f) Notwithstanding any other provisions of law, an insurer may declare and pay, subject to the provisions of this section, an extraordinary dividend or distribution from its gross paid-in and contributed surplus, provided that:

(1) The dividend or distribution shall be made only upon a determination by the board of directors of the insurer that the assets of the insurer are in excess of the needs of its business; and

(2) Each dividend or distribution, when made, shall be identified as a distribution from gross paid-in and contributed surplus, and the amount per share shall be disclosed to the shareholders receiving the dividend or distribution concurrently with its distribution.

History. Acts 1971, No. 288, § 7; 1973, No. 305, § 1; A.S.A. 1947, § 66-5007; Acts 1991, No. 723, § 24; 1993, No. 901, § 11; 2001, No. 1603, § 10; 2005, No. 506, § 23; 2007, No. 496, § 10; 2015, No. 1223, §§ 10, 11; 2017, No. 386, § 4.

Amendments. The 2017 amendment added “including” at the end of the introductory language in (a)(2)(B)(iii); added (a)(2)(B)(iii)(a); and inserted “Agreements” in (a)(2)(B)(iii)(b).

23-63-516. Examination.

(a) **POWER OF INSURANCE COMMISSIONER.** Subject to the limitation contained in this section and in addition to the powers of the Insurance Commissioner under § 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq. to examine insurers, the commissioner may examine an insurer registered under § 23-63-514 and the insurer’s affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(b) **ACCESS TO BOOKS AND RECORDS.**

(1) The commissioner may order an insurer registered under § 23-63-514 to produce books, records, or other information in the possession of affiliates as reasonably necessary to determine the registered insurer’s compliance with this subchapter.

(2)(A) In order to determine compliance with this subchapter, the commissioner may order an insurer registered under § 23-63-514 to produce information not in the possession of the insurer if the insurer can obtain access to the information under contractual relationships, statutory obligations, or other methods.

(B)(i) If the insurer is unable to produce the information requested by the commissioner, the insurer shall provide an acceptable explanation to the commissioner and identify the holder of the information.

(ii) However, if it appears to the commissioner that the insurer’s explanation is without merit, the commissioner, after notice and a hearing, may:

(a) Require the insurer to pay a penalty of one hundred dollars (\$100) per day until the commissioner receives the requested information; or

(b) Suspend or revoke the insurer’s certificate of authority to transact business in this state.

(c) **USE OF CONSULTANTS.** The commissioner may retain at the insurer’s expense attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner’s staff as reasonably necessary to assist in an examination under subsection (a) of this section. Any

person retained as a consultant shall be under the direction and control of the commissioner and shall act in an advisory capacity.

(d) **EXPENSES.** Each registered insurer producing for examination records, books, and papers under subsection (a) of this section shall be liable for and shall pay the expense of the examination in accordance with § 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq.

(e) **PRODUCTION.**

(1)(A) If an insurer fails to comply with an order of the commissioner, the commissioner may examine the insurer's affiliates to obtain the information.

(B) The commissioner may issue subpoenas, administer oaths, and examine under oath any person for purposes of determining compliance with this section.

(2)(A) Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon a proper showing, the court may enter an order compelling the witness to appear and testify or to produce documentary evidence.

(B) Failure to obey the court order is punishable as contempt of court.

(3)(A) When subpoenaed, a person shall attend as a witness at the place specified in the subpoena anywhere in this state.

(B)(i) A person under subpoena is entitled to the same fees and mileage as a witness in a civil action in a circuit court in this state.

(ii) In order to receive reimbursement for fees, mileage, and actual expenses, if any, necessarily incurred by a person under subpoena, the fees, mileage, and actual expenses shall be itemized, charged to, and paid by the insurer being examined.

History. Acts 1971, No. 288, § 8; A.S.A. 1947, § 66-5008; Acts 1991, No. 723, § 25; 2015, No. 1223, § 12.

23-63-517. Confidential treatment.

(a)(1) All information and documents obtained by or disclosed to the Insurance Commissioner or any other person in the course of an examination or investigation made under § 23-63-516 and all information reported under §§ 23-63-514 and 23-63-515 shall be given confidential treatment and shall not be subject to subpoena or discovery or admissible in evidence in any private civil action or be made public by the commissioner under the Freedom of Information Act of 1967, § 25-19-101 et seq., or any other public records law, or by the National Association of Insurance Commissioners. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's duties.

(2) The information, documents, and copies of the information shall not be subject to subpoena or be made public without the prior written consent of the insurer to which it pertains unless the commissioner,

after giving the insurer and any of the insurer's affiliates that may be affected notice and an opportunity to be heard, determines that the interests of policyholders, shareholders, or the public will be served by the publication of the information.

(3) In that event, the commissioner may publish any part of the information in the manner the commissioner considers appropriate.

(b) The commissioner and any person who received documents, materials, or other information while acting on behalf of the commissioner or person with whom the commissioner shares the documents, materials, or other information under this section shall not be permitted or required to testify in a private civil action concerning confidential documents, materials, or information subject to subsection (a) of this section.

(c)(1) In order to assist in the performance of the commissioner's duties under this section, the commissioner may share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to this section, with other state, federal, and international regulatory agencies or law enforcement authorities, the National Association of Insurance Commissioners and its affiliates and subsidiaries, and members of any supervisory college if the recipient or recipients agree in writing to maintain the confidentiality and privileged status of the information and the recipient or recipients verify the existing legal authority to maintain the confidentiality of the information.

(2) Notwithstanding subdivision (c)(1) of this section, the commissioner may only share confidential and privileged documents, material, or information under § 23-63-514(m) with the state commissioners of those states that have similar statutes or rules that are substantially similar to subsection (a) of this section and that agree in writing not to disclose the information.

(3)(A) The commissioner may receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions.

(B) Documents, materials, or information received by the commissioner under subdivision (c)(3)(A) of this section shall be maintained as confidential or privileged under the laws of the source jurisdiction if the commissioner is provided with notice or receives the documents, materials, or information with the understanding that the information is confidential or privileged.

(4)(A) If the commissioner intends to share or use information with the National Association of Insurance Commissioners, the commissioner shall enter into a written agreement with the National Association of Insurance Commissioners governing the sharing and use of the information provided under this section.

(B) The written agreement under subdivision (c)(4)(A) of this section shall:

(i) Specify the procedures and protocols regarding the confidentiality and security of information that is shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal, or international regulators;

(ii) Specify that ownership of the information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries, remains with the commissioner, and that the National Association of Insurance Commissioners' use of the information is subject to the direction of the commissioner;

(iii) Require prompt notice be given to an insurer whose confidential information is shared with and in the possession of the National Association of Insurance Commissioners under this section that the confidential information is subject to a request or subpoena to the National Association of Insurance Commissioners to disclose or produce the confidential information; and

(iv) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information of the insurer shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries under this section.

(d) The sharing of information by the commissioner under this section does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this section.

(e) A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information does not occur as a result of disclosure to the commissioner under this section or as a result of sharing the documents, materials, or information as authorized in this section.

(f)(1) Documents, materials, or other information shared under this section that are in the possession or control of the National Association of Insurance Commissioners shall remain confidential by law and are privileged.

(2) The information described under subdivision (f)(1) of this section is not:

(A) Subject to:

(i) The Freedom of Information Act of 1967, § 25-19-101 et seq.;

(ii) Subpoena; or

(iii) Discovery; or

(B) Admissible in evidence in any private civil action.

History. Acts 1971, No. 288, § 9; A.S.A. in (c)(4)(B)(iii), deleted "to" following "notice", inserted "with" following "shared", and inserted "that the confidential information".
1947, § 66-5009; Acts 1991, No. 723, § 26;
2015, No. 1223, § 13; 2017, No. 334, § 5.

Amendments. The 2017 amendment,

23-63-518. Rules.

After compliance with §§ 23-61-108 and 23-61-304 of the Arkansas Insurance Code, the Insurance Commissioner may issue such rules and orders as shall be necessary to carry out the provisions of this subchapter.

History. Acts 1971, No. 288, § 10; A.S.A. 1947, § 66-5010; Acts 2019, No. 315, § 2631.

deleted “and regulations” following “rules” in the section heading; and deleted “regulations” following “rules” in the text.

Amendments. The 2019 amendment

23-63-520. Voting of securities.

(a) **WHEN PROHIBITED.**

(1) No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the provisions of this subchapter or of any rule or order issued by the Insurance Commissioner pursuant to this subchapter may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding.

(2) However, no action taken at any meeting shall be invalidated by the voting of the securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered.

(3) If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this subchapter or of any rule or order issued by the commissioner pursuant to it, the insurer or the commissioner may apply to the Pulaski County Circuit Court to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of §§ 23-63-506 — 23-63-513 or any rule or order issued by the commissioner pursuant to it to enjoin the voting of any security so acquired, to void any vote of a security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders, or the public may require.

(b) **SEQUESTRATION OF VOTING SECURITIES.** In any case in which a person has acquired or is proposing to acquire any voting securities in violation of this subchapter or any rule, regulation, or order issued by the commissioner pursuant to it, the Pulaski County Circuit Court may, on such notice as the court deems appropriate and upon the application of the insurer or the commissioner, seize or sequester any voting securities of the insurer owned directly or indirectly by the person and issue such orders with respect thereto as may be appropriate to effectuate the provisions of this subchapter. Notwithstanding any other provisions of law, for the purposes of this subchapter, the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

History. Acts 1971, No. 288, § 12; A.S.A. 1947, § 66-5012; Acts 2019, No. 315, § 2632.

Amendments. The 2019 amendment deleted “regulation” following “rule” in (a)(1), and twice in (a)(3).

23-63-521. Injunctions.

Whenever it appears to the Insurance Commissioner that any insurer or any director, officer, employee, or agent of an insurer has committed or is about to commit a violation of this subchapter or of any rule or order issued by the commissioner pursuant to it, the commissioner may apply to the Pulaski County Circuit Court for an order enjoining the insurer or the director, officer, employee, or agent of the insurer from violating or continuing to violate this subchapter or any rule or order, and for such other relief as the nature of the case and the interests of the insurer’s policyholders, creditors, and shareholders or the public may require.

History. Acts 1971, No. 288, § 12; A.S.A. 1947, § 66-5012; Acts 2019, No. 315, § 2633.

Amendments. The 2019 amendment deleted “regulation” following “rule” twice.

23-63-531. Supervisory colleges.

(a)(1) The Insurance Commissioner may participate in a supervisory college for a domestic insurer registered under § 23-63-514 that is part of an insurance holding company system with international operations to determine compliance by the insurer with this section.

(2) The commissioner may participate in a supervisory college for a domestic insurer that includes without limitation:

(A) Initiating the establishment of a supervisory college;

(B) Clarifying the membership and participation of other supervisors in the supervisory college;

(C) Clarifying the functions of the supervisory college, the role of other regulators, and establishing a group-wide supervisor;

(D) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and procedures to share information; and

(E) Establishing a crisis management plan.

(b)(1)(A) A domestic insurer subject to this section is liable for and shall pay any reasonable expenses, including reasonable travel expenses, of the commissioner’s participation in a supervisory college under subsection (c) of this section.

(B) The commissioner may establish a regular assessment to the domestic insurer for the expenses described in subdivision (b)(1)(A) of this section.

(2) For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the domestic insurer or its affiliates.

(c)(1) In order to assess the business strategy, financial, legal, and regulatory position, risk exposure, risk management, and governance

processes, and as part of the examination of individual insurers according to § 23-63-516, the commissioner may participate in a supervisory college with other regulators that are charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies.

(2) The commissioner may enter into agreements according to § 23-63-517(c) providing the basis for cooperation among the commissioner, the other regulatory agencies, and the activities of the supervisory college.

(3) This section does not delegate to the supervisory college any authority of the commissioner to regulate or supervise the domestic insurer or its affiliates within the commissioner's jurisdiction.

History. Acts 2015, No. 1223, § 14.

23-63-532. Group-wide supervision of internationally active insurance groups.

(a)(1) The Insurance Commissioner may act as a group-wide supervisor for any internationally active insurance group under this section.

(2) However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor when the internationally active insurance group:

(A) Does not have substantial insurance operations in the United States;

(B) Has substantial insurance operations in the United States, but not in this state; or

(C) Has substantial insurance operations in the United States and this state, but the commissioner has determined under subsections (b) and (f) of this section that the other regulatory official is the appropriate group-wide supervisor.

(3) An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment of a regulatory official as to a group-wide supervisor under this section.

(b)(1) In cooperation with other state, federal, and international regulatory agencies, the commissioner may identify a single group-wide supervisor for an internationally active insurance group.

(2)(A) The commissioner may determine that the group-wide supervisor identified in subdivision (b)(1) of this section is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state.

(B) However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group.

(C) The commissioner shall determine the appropriate group-wide supervisor under subdivision (b)(2)(B) of this section by considering the following:

(i) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(ii) The place of domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group;

(iii) The location of the executive offices or largest operational offices of the internationally active insurance group;

(iv) Whether or not another regulatory official is acting or seeks to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

(a) Substantially similar to the system of regulation provided under the laws of this state; or

(b) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(v) Whether or not another regulatory official who is acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

(3) A commissioner who is identified under this section as the group-wide supervisor may determine that it is in the best interest of the internationally active insurance group to acknowledge another supervisor to serve as the group-wide supervisor.

(4) The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in subdivision (b)(2)(C) of this section in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internally active insurance group after consultation with the internationally active insurance group.

(c)(1) Notwithstanding any other law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor.

(2) However, the commissioner shall reconsider a determination or acknowledgement of a regulatory official as the group-wide supervisor if a material change in the internationally active insurance group results in:

(A) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities; or

(B) This state's becoming the place of domicile of the top-tiered insurer in the insurance holding company system of the internationally active insurance group.

(d)(1) Under § 23-63-516, the commissioner may collect from an insurer registered under § 23-63-514 any information necessary to determine whether or not the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor.

(2) Before issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered under § 23-63-514 and the ultimate controlling person within the internationally active insurance group.

(3) The internationally active insurance group shall have at least thirty (30) days to provide the commissioner with any additional information requested by the commissioner to assist the commissioner to make a determination.

(4) The commissioner shall publish on the State Insurance Department's website and any other required public records website maintained by the state the identity of the internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(e) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner may engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

(A) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(B) Reasonable and effective mitigation measures are in place;

(2) Request information from any member of an internationally active insurance group subject to the commissioner's supervision that the commissioner determines is necessary and appropriate to assess enterprise risk, including without limitation information concerning members of the internationally active insurance group's:

(A) Governance, risk assessment, and management;

(B) Capital adequacy; and

(C) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal, and international regulatory agencies for members of the internationally active insurance group and share relevant information subject to § 23-63-517, through supervisory colleges under § 23-63-531, or otherwise permitted;

(5)(A) Enter into agreements with or obtain documentation from any insurer registered under § 23-63-514, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group to provide the basis for the commissioner's

role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials.

(B) An agreement or documentation shall not serve as evidence in any proceeding that an insurer or member of an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Enter into other group-wide supervision activities that are consistent with the authorities and purposes in this section, as considered necessary by the commissioner.

(f) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the commissioner may cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor if:

(1) The commissioner's cooperation is not a violation of this state's law; and

(2)(A) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups.

(B) If recognition and cooperation are not reasonably reciprocal, the commissioner may refuse recognition and cooperation.

(g) The commissioner may enter into agreements with or obtain documentation from an insurer registered under § 23-63-514, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group, that provide the basis for a regulatory official's role as group-wide supervisor.

(h) The commissioner may promulgate rules necessary for the administration of this section.

(i) A registered insurer subject to this section is liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals, and all reasonable travel expenses.

History. Acts 2015, No. 1223, § 14.

SUBCHAPTER 6 — FINANCIAL REPORTING STANDARDS

SECTION.

23-63-601. Definition.

23-63-611. Asset valuation.

23-63-613. Use of new and revised manuals — Rulemaking authority.

Effective Dates. Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled ‘Funding and

classification of cabinet-level department secretaries’ and ‘Transformation and Efficiencies Act transition team’ should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019.”

23-63-601. Definition.

In any determination of the financial condition, including whether an asset is allowable, of a domestic insurer, domestic title insurer, or other domestic regulated entities reporting to the Insurance Commissioner, including health maintenance organizations, hospital or medical service corporations, farmers’ mutual aid associations or companies, and other licensees, all hereinafter called “reporting entities” for purposes of this subchapter, the definition of an “asset” contained in the National Association of Insurance Commissioners’ publication as it existed on January 1, 2001, entitled the “Accounting Practices and Procedures Manual”, with certain additions, will be used in the determination. Additions shall include, but may not be limited to, the following:

- (1)(A) Electronic data processing equipment, licenses, and operating system software, excluding any amount paid to officers and employees of the reporting entity, necessary for installation and use of a data processing or accounting system, or both, to be used in connection with the business of the insurer or reporting entity.
- (B) Commencing on and after January 1, 2001, assets allowed under this section, as well as nonoperating system software, shall be accounted for in accordance with the National Association of Insurance Commissioners’ publication as it existed on January 1, 2001, entitled the “Accounting Practices and Procedures Manual”; and
- (2) Other assets as specified by the commissioner in a rule.

History. Acts 1959, No. 148, § 82; 1961, No. 466, § 9; 1973, No. 195, § 1; 1975, No. 729, § 7; 1981, No. 809, § 2; A.S.A. 1947, § 66-2501; Acts 2001, No. 1566, § 3; 2019, No. 315, § 2634.

Amendments. The 2019 amendment deleted “or regulation” following “rule” in (2).

23-63-611. Asset valuation.

Assets of reporting entities shall be valued in accordance with the following:

- (1) Bonds and securities shall be valued in accordance with the methods specified in the National Association of Insurance Commissioners’ publication as it existed on January 1, 2001, entitled the

"Valuation of Securities Manual", prepared by the Securities Valuation Office;

(2) Shares of stock shall be valued in accordance with the methods specified in the National Association of Insurance Commissioners' publication as it existed on January 1, 2001, entitled the "Accounting Practices and Procedures Manual"; and

(3) Other assets shall be valued as specified by the Insurance Commissioner in a rule, in accordance with the provisions of § 23-63-601(2), which method of valuation is not inconsistent with the National Association of Insurance Commissioners' publication as it existed on January 1, 2001, entitled the "Valuation of Securities Manual", prepared by the Securities Valuation Office.

History. Acts 1959, No. 148, §§ 93, 94; A.S.A. 1947, §§ 66-2512, 66-2513; Acts 1995, No. 1272, § 13; 2001, No. 1566, § 9; 2019, No. 315, § 2635. **Amendments.** The 2019 amendment deleted "and regulation" following "rule" in (3).

23-63-613. Use of new and revised manuals — Rulemaking authority.

(a)(1) The Insurance Commissioner is authorized to employ the standards and requirements set forth in publications recited in this subchapter and adopted and published by the National Association of Insurance Commissioners, including, but not limited to, those listed in this subchapter.

(2) The publications identified in subdivision (a)(1) of this section are hereby adopted in their present form as of August 13, 2001.

(3) The commissioner is authorized and empowered to promulgate rules for the purposes of adopting all or part of other financial standards publications of the National Association of Insurance Commissioners or publications by other authors if the commissioner determines that such an action is in the best interest of the public.

(4) Upon mailing of written notice by the commissioner to all domestic reporting entities of the promulgation and publication by the National Association of Insurance Commissioners or other authors of amendments, revisions, or modifications to any publication previously adopted by the commissioner in this subchapter, such published amendments, revisions, or modifications shall become effective on the date designated by the commissioner in the written notice, which date shall not be earlier than eight (8) months after the date of mailing of the notice.

(b) The commissioner is authorized and empowered to adopt financial standards regulations for the purpose of modifying, amending, or revising any publication promulgated by the National Association of Insurance Commissioners or other authors, or any published amendments, modifications, or revisions to any such publications if the commissioner determines that such an action is in the best interest of the public. In this event, the effective date of any modification, amendment, or revision shall be the effective date of the regulation.

History. Acts 1959, No. 148, § 96; A.S.A. 1947, § 66-2515; Acts 1995, No. 1272, § 15; 2001, No. 1566, § 11; 2019, No. 315, § 2636.

Amendments. The 2019 amendment substituted “rules” for “regulations” in (a)(3).

SUBCHAPTER 8 — INVESTMENTS

SECTION.

23-63-802. Eligible investments.

23-63-805. Diversification of investments.

23-63-814. Corporate bonds and debentures.

23-63-815. Preferred or guaranteed stock.

SECTION.

23-63-824. Foreign securities.

23-63-840. Mortgage-backed securities.

23-63-842. Asset-backed securities — Definitions.

23-63-802. Eligible investments.

(a) Insurers shall invest in, or lend their funds on the security of, and shall hold as invested assets only eligible investments as prescribed in this subchapter.

(b) Any particular investment held by an insurer on January 1, 1960, and which was a legal investment at the time it was made, or which the insurer was legally entitled to possess immediately prior to January 1, 1960, shall be deemed to be an eligible investment.

(c) Eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in subsection (b) of this section.

(d) Any investment limitation based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of the December 31 next preceding the date of acquisition of the investment by the insurer, or as shown by a current financial statement filed with the commissioner.

(e) None of the requirements, restrictions, limitations, or prohibitions for investments made under this subchapter, or contained in any regulation promulgated pursuant thereto, shall be preempted by the provisions of section 106 of Title 1 of the Secondary Mortgage Market Enhancement Act of 1984. The provisions of this subchapter and any rules promulgated pursuant thereto that pertain to investments in the categories of securities specified in paragraphs (1) and (2) of subsection (a) of the Secondary Mortgage Market Enhancement Act shall remain in full force and effect notwithstanding the enactment of the Secondary Mortgage Market Enhancement Act.

History. Acts 1959, No. 148, § 98; A.S.A. 1947, § 66-2602; Acts 1991, No. 1123, § 1; 1993, No. 527, § 5; 2019, No. 315, § 2637.

Amendments. The 2019 amendment substituted “rules” for “regulations” in the second sentence of (e).

23-63-805. Diversification of investments.

An insurer shall invest in or hold as admitted assets categories of investments only within applicable limits as follows:

(1) ONE PERSON.

(A)(i)(a) Except with the consent of the Insurance Commissioner and except as otherwise specified in this subchapter, an insurer shall not have, directly or indirectly through an investment subsidiary, an investment under this subchapter if, as a result of and after giving effect to the investment, the insurer holds more than five percent (5%) of its admitted assets in investments of all kinds issued, assumed, accepted, insured, or guaranteed by a single person or five percent (5%) of its admitted assets in investments in the voting securities of a depository institution or any company that controls the institution.

(b) The five percent (5%) limitation under subdivision (1)(A)(i)(a) of this section shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(ii)(a) Investments in certificates of deposit and savings and loan association deposits in any one (1) person may be the greater of:

(1) Ten percent (10%) of the insurer's assets; or

(2) The maximum amount of federal insurance applicable to the deposit.

(b) The restriction under subdivision (1)(A)(i)(a) of this section does not apply to general obligations of the United States or any state or include policy loans made under § 23-63-821.

(iii) The applicable limitation shall be twenty-five percent (25%) rather than five percent (5%) for investments permitted under § 23-63-812.

(B) If upon enactment, the immediate application of this provision would have the effect of reducing the admitted asset value of assets held by a particular insurer, the insurer may continue to reflect as admitted those assets that would be admissible but for the enactment of this provision, until the annual statement filing for the year ended December 31, 2004;

(2) MINIMUM CAPITAL. An insurer, other than a title insurer, shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under the Arkansas Insurance Code of a domestic stock insurer transacting like kinds of insurance only in cash and the securities provided for under §§ 23-63-806, 23-63-808, and 23-63-826;

(3) LIFE INSURANCE RESERVES. A life insurer shall also invest and keep invested its funds in amount not less than seventy-five percent (75%) of the reserves under its life insurance policies and annuity contracts, other than variable annuities, in force, in cash, securities, or investments allowed under this subchapter, other than stocks of subsidiaries of the insurer;

(4) **COMMON STOCKS.** An insurer, other than a life insurer, may invest and have invested at any one (1) time an aggregate amount not more than twenty-five percent (25%) of its assets in all stocks under § 23-63-816 concerning common stocks, § 23-63-817 concerning insurance stocks, and § 23-63-820 concerning investment trust securities. A life insurer may so invest and have invested in the stocks no more than ten percent (10%) of its assets. This provision shall not apply as to stock of a controlled or subsidiary insurance corporation or other corporation under § 23-63-817 or § 23-63-818, or as to variable annuities;

(5) **MISCELLANEOUS.** Except with the commissioner's consent, an insurer shall not have invested at any one (1) time more than twenty percent (20%) of its assets in the class of securities described in §§ 23-63-815 and 23-63-819;

(6) **OTHER SPECIFIC LIMITS.** Limits as to investments in the category of real estate shall be as provided in § 23-63-828. Other specific limits shall apply as stated in the sections dealing with other respective kinds of investments; and

(7) **LIMITATIONS ON ACQUISITIONS AND INVESTMENTS.** Notwithstanding any other provision of this subchapter to the contrary:

(A)(i) No insurer shall acquire, directly or indirectly, any medium grade or lower grade obligation of any institution if, after giving effect to any such acquisition, the aggregate amount of all medium grade and lower grade obligations then held by the domestic insurer would exceed twenty percent (20%) of its admitted assets, provided that no more than ten percent (10%) of its admitted assets consist of obligations rated four (4), five (5), or six (6) by the Securities Valuation Office of the National Association of Insurance Commissioners, and no more than three percent (3%) of its admitted assets consist of obligations rated five (5) or six (6) by the Securities Valuation Office, and no more than one percent (1%) of its admitted assets consist of obligations rated six (6) by the Securities Valuation Office. Attaining or exceeding the limit of any one (1) category shall not preclude an insurer from acquiring obligations in other categories subject to the specific and multicategory limits.

(ii)(a) No insurer may invest more than an aggregate of one percent (1%) of its admitted assets in medium grade obligations issued, guaranteed, or insured by any one (1) person or institution, nor may it invest more than one-half of one percent (0.5%) of its admitted assets in lower grade obligations issued, guaranteed, or insured by any one (1) person or institution.

(b) In the case of a downgrade of securities held by an insurer, the commissioner may grant temporary relief from the investment limitations on medium grade obligations and lower grade obligations.

(iii) An insurer may acquire an obligation of an institution in which the insurer already has one (1) or more obligations, if the obligation is acquired in order to protect an investment previously made in the obligations of the institution. Provided, that all such acquired obligations shall not exceed one-half of one percent (0.5%) of the insurer's admitted assets.

(iv) Nothing contained in this subdivision (7):

(a) Shall prohibit an insurer from acquiring any obligations which it has committed to acquire if the insurer would have been permitted to acquire that obligation pursuant to this subchapter on the date on which the insurer committed to purchase that obligation;

(b) Shall prohibit an insurer from acquiring an obligation as a result of restructuring of a medium or lower grade obligation already held; or

(c) Shall require an insurer to sell or otherwise dispose of any obligation legally acquired prior to March 16, 1993.

(v)(a) The board of directors of any insurer which acquires or invests, directly or indirectly, more than two percent (2%) of its admitted assets in medium grade and lower grade obligations of any institution shall adopt a written plan for the making of such investments.

(b) The plan, in addition to the guidelines with respect to the quality of the issues invested in, shall contain diversification standards, including, but not limited to, standards for issuer, industry, duration, liquidity, and geographic location; and

(B) For purposes of this subdivision (7):

(i) "Admitted assets" means the amount thereof as of the last day of the most recently concluded annual statement year, computed in the same manner as admitted assets pursuant to § 23-63-601 et seq.;

(ii) "Aggregate amount" of medium grade and lower grade obligations means the aggregate statutory statement value thereof;

(iii) "Institution" means a corporation, a joint-stock company, an association, a trust, a business partnership, a business joint venture, or similar entity;

(iv) "Lower grade obligations" means obligations which are rated five (5) or six (6) by the Securities Valuation Office; and

(v) "Medium grade obligations" means obligations which are rated three (3) or four (4) by the Securities Valuation Office.

History. Acts 1959, No. 148, § 101; 527, §§ 7, 8; 2001, No. 1604, § 35; 2005, 1981, No. 809, § 3; 1983, No. 522, § 7; No. 506, §§ 24-26; 2015, No. 231, § 3. A.S.A. 1947, § 66-2605; Acts 1993, No.

23-63-814. Corporate bonds and debentures.

(a) An insurer may invest in bonds, debentures, notes, and other evidences of indebtedness issued, assumed, or guaranteed by any solvent institution existing under the laws of the United States or of Canada, or any state or province thereof, which are not in default as to principal or interest and which are secured by collateral worth at least fifty percent (50%) more than the par value of the entire issue of such obligations, but only if not more than one-third ($\frac{1}{3}$) of the total value of the required collateral consists of common stock.

(b) An insurer may invest in secured and unsecured obligations of the institutions, other than obligations described in subsection (a) of

this section, that are not in default as to principal or interest, if the obligations:

(1) Are rated or expected to be rated by the Securities Valuation Office of the National Association of Insurance Commissioners, if not otherwise exempt under the Purposes and Procedures Manual of the Securities Valuation Office of the National Association of Insurance Commissioners; or

(2) Bear interest at a fixed rate, with mandatory principal and interest due at specified times, and if the net earnings of the issuing, assuming, or guaranteeing institution available for its fixed charges for five (5) fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than one and one-half ($1\frac{1}{2}$) times its average annual fixed charges applicable to the period and if, during either of the last two (2) years of the period, the net earnings have been not less than one and one-half ($1\frac{1}{2}$) times its fixed charges for the year.

History. Acts 1959, No. 148, § 110;
A.S.A. 1947, § 66-2614; Acts 2015, No.
1223, § 15.

23-63-815. Preferred or guaranteed stock.

(a) An insurer may invest in preferred or guaranteed stocks or shares of any solvent institution existing under the laws of the United States or of Canada, or of any state or province thereof, if at the date of the acquisition of the investment by the insurer:

(1) The net earnings of the institution available for its fixed charges during each of the last two (2) years have been, and during each of the last five (5) years have averaged, not less than one and one-half ($1\frac{1}{2}$) times the sum of its average annual fixed charges, if any, its average annual maximum contingent interest, if any, and its average annual preferred dividend requirements; or

(2) The securities are:

(A) Rated "1" or "2" by the Securities Valuation Office of the National Association of Insurance Commissioners; or

(B) Exempt under the Purposes and Procedures Manual of the Securities Valuation Office of the National Association of Insurance Commissioners.

(b) For the purposes of this section, the computation shall refer to the fiscal years immediately preceding the date of acquisition of the investment by the insurer, and the term "preferred dividend requirement" shall be deemed to mean cumulative or noncumulative dividends, whether paid or not.

History. Acts 1959, No. 148, § 111;
A.S.A. 1947, § 66-2615; Acts 1993, No.
527, § 9; 2015, No. 1223, § 16.

23-63-824. Foreign securities.

(a) An insurer may acquire investments or engage in investment practices with entities or institutions of or in foreign jurisdictions of substantially the same type that an insurer may acquire under this subchapter for investments in the United States if, as a result of and after giving effect to the investment:

(1) The aggregate amount of foreign domiciled investments held by the insurer under this subsection does not exceed twenty percent (20%) of the insurer's admitted assets;

(2) The aggregate amount of foreign investments held by the insurer under this subsection, domiciled in a single foreign jurisdiction, does not exceed:

(A) Ten percent (10%) of its admitted assets to a foreign jurisdiction that has a sovereign debt rating of "1" by the Securities Valuation Office of the National Association of Insurance Commissioners; or

(B) Three percent (3%) of its admitted assets to any other foreign jurisdiction; and

(3) The insurer does not hold more than three percent (3%) of its admitted assets in investments of any kind issued, assumed, accepted, insured, or guaranteed by a single foreign entity or institution.

(b) Except as provided in § 23-63-805, an insurer may acquire investments or engage in investment practices denominated in foreign currencies when the investments are foreign investments under subsection (a) of this section or the investments are limited to foreign currency exposure as a result of the termination or expiration of a hedging transaction concerning investments denominated in a foreign currency if, as a result of and after giving effect to the investment:

(1) The aggregate amount of investments held by the insurer under this subsection denominated in foreign currencies does not exceed ten percent (10%) of its admitted assets;

(2) The aggregate amount of investments held by the insurer under this subsection denominated in the foreign currency of a single foreign jurisdiction does not exceed three percent (3%) of its admitted assets as to a foreign jurisdiction that does not have a sovereign debt rating of "1" by the Securities Valuation Office of the National Association of Insurance Commissioners; and

(3) An investment shall not be considered denominated in a foreign currency if the acquiring insurer:

(A) Enters into at least one (1) transaction under § 23-63-841; and

(B) The business entity counterparty agrees or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate that effectively insulates the investment cash flows against future fluctuations in currency exchange rates during the time a contract is in effect.

(c) Canadian securities that are eligible for investment under other provisions of this subchapter are not subject to this section.

History. Acts 1959, No. 148, § 120; A.S.A. 1947, § 66-2624; Acts 1991, No. 1123, § 20; 1993, No. 527, § 11; 2015, No. 1223, § 17.

23-63-840. Mortgage-backed securities.

(a) An insurer may invest in mortgage-backed securities, including without limitation collateralized mortgage obligations and other obligations for the payment of money secured by participation certificates or loans secured, directly or indirectly, by real estate mortgages or deeds of trust if, at the time the investment is made:

(1) The entity issuing the obligation is not in default in the payment of interest on the obligation;

(2) The specific investment within that collateralized mortgage obligation is not a zero coupon class, residual interest, or a class designated as principal or interest only;

(3)(A) The obligation, participation certificate, or loan is fully guaranteed or insured, as to principal and interest, by the United States, an agency or instrumentality of the United States, or any state or territory of the United States or any agency thereof.

(B) The aggregate value of any one (1) issue of an obligation under subdivision (a)(3)(A) of this section shall not exceed five percent (5%) of the insurer's admitted assets; or

(4)(A) The obligation, participation certificate, or loan is held by the issuer directly or through a trustee for the benefit of the obligee.

(B) The aggregate value of any one (1) issue of an obligation under subdivision (a)(4)(A) of this section shall not exceed three percent (3%) of the insurer's admitted assets.

(b)(1) The aggregate value of an insurer's investments under subdivision (a)(3)(A) of this section shall not exceed fifty percent (50%) of the insurer's admitted assets.

(2) The aggregate value of an insurer's investments under subdivision (a)(4)(A) of this section shall not exceed fifteen percent (15%) of the insurer's admitted assets unless the insurer received prior approval from the Insurance Commissioner for a specified amount not to exceed thirty percent (30%) of the insurer's admitted assets.

(c) An insurer may invest up to ten percent (10%) of its assets in zero coupon, residual interest, or principal-and-interest-only classes of mortgage-backed securities if the underlying mortgages pledged to the repayment of principal and interest of the mortgage-backed securities are unconditionally guaranteed as to timely repayment of principal and interest by the United States or any agency or instrumentality of the United States.

(d) For purposes of the "one person" diversification restriction under § 23-63-805(1), mortgage-backed securities issued by the United States or any agency or instrumentality of the United States shall not be considered investments in or loans upon the security of the obligations, property, or securities of the United States or any agency or instrumentality of the United States.

History. Acts 1989, No. 772, § 4; 2001, No. 1604, § 38; 2015, No. 1223, § 18.

23-63-842. Asset-backed securities — Definitions.

(a) As used in this section:

(1)(A) “Asset-backed security” means any security or other instrument representing or evidencing an interest in, a loan to, a participation in a loan to, or any other right to receive payments from a borrower included in a pool of obligations held by an issuer that has a primary business activity of the acquisition and holding of financial assets, directly or through a trustee, for the benefit of the issuer.

(B) “Asset-backed security” does not include an investment authorized by any other provision of this subchapter; and

(2) “Financial asset” means a single asset or a pool of assets consisting of interest-bearing obligations or other contractual obligations representing or constituting the right to receive payment from the asset or pool of assets.

(b)(1) An insurer may invest in asset-backed securities if the investment in any one (1) issue of asset-backed securities does not exceed two percent (2%) of the admitted assets of the investing insurance company as shown by the insurer’s last annual statement or a recent quarterly financial statement filed with the Insurance Commissioner.

(2) Each issue secured by a unique pool of assets shall constitute a single issue regardless of any other obligations or securities issued by the same or any affiliated issuer.

(c) Investments in asset-backed securities under subsection (b) of this section shall not exceed twenty percent (20%) of the insurer’s admitted assets.

History. Acts 2015, No. 1223, § 19.

SUBCHAPTER 12 — ANNUAL REPORTS BY PROPERTY AND CASUALTY INSURERS

[Repealed.]

SECTION.

23-63-1201 — 23-63-1205. [Repealed.]

23-63-1201 — 23-63-1205. [Repealed.]

Publishers Note. These sections, concerning annual reports by property and casualty insurers, were repealed by Acts 2015, No. 1210, § 2. The sections were derived from the following sources:

23-63-1201. Acts 1993, No. 166, § 1.

23-63-1202. Acts 1993, No. 166, § 1;
1995, No. 108, § 2; 1997, No. 1111, § 1.

23-63-1203. Acts 1993, No. 166, § 1;
1995, No. 108, § 1.

23-63-1204. Acts 1993, No. 166, § 1.

23-63-1205. Acts 1997, No. 1111, § 2.

SUBCHAPTER 13 — RISK-BASED CAPITAL ACT

SECTION.

23-63-1302. Definitions.

23-63-1303. RBC reports.

23-63-1304. Company action level event
— Definition.

SECTION.

23-63-1307. Mandatory control level
event — Definition.

23-63-1310. Supplemental provisions —
Rules — Exemption.

23-63-1302. Definitions.

As used in this subchapter:

(1) “Adjusted RBC report” means a risk-based capital report that has been adjusted by the Insurance Commissioner under § 23-63-1303(e);

(2) “Corrective order” means an order issued by the commissioner specifying corrective actions that the commissioner has determined are needed;

(3) “Domestic insurer” means an insurance company domiciled in this state;

(4) “Foreign insurer” means an insurance company that may do business in this state under § 23-63-201 et seq. but is not domiciled in this state;

(5) “Fraternal benefit society” means an insurance company or society organized and licensed under Arkansas Code Title 23, Chapter 74;

(6) “Life or accident and health insurer” means:

(A) An insurance company authorized to transact a life or accident and health insurance business under § 23-63-201 et seq.; or

(B) An authorized property and casualty insurer writing only accident and health insurance;

(7) “NAIC” means the National Association of Insurance Commissioners;

(8) “Negative trend” means, with respect to a life or accident and health insurer or a fraternal benefit society, a negative trend over a period, as determined according to the trend test calculation included in the RBC instructions for a life or accident and health insurer or RBC instructions for a fraternal benefit society;

(9)(A) “Property or casualty insurer” means an insurance company authorized to transact property or casualty insurance business under § 23-63-201 et seq., including farmers’ mutual aid associations and fraternal benefit societies.

(B) “Property or casualty insurer” does not include:

(i) Monoline mortgage guaranty insurers;

(ii) Financial guaranty insurers; or

(iii) Title insurers;

(10) “RBC” means risk-based capital;

(11) “RBC instructions” means the RBC report including risk-based capital instructions adopted by the NAIC, as amended by the NAIC;

(12) “RBC level” means an insurer’s company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC when:

(A) "Authorized control level RBC" means the number determined under the risk-based capital formula according to the RBC instructions;

(B) "Company action level RBC" means, with respect to an insurer, the product of two (2) and its authorized control level RBC;

(C) "Mandatory control level RBC" means the product of seven-tenths of one percent (0.7%) and the authorized control level RBC; and

(D) "Regulatory action level RBC" means the product of one and five-tenths (1.5) and its authorized control level RBC;

(13) "RBC plan" means a comprehensive financial plan containing the elements named in § 23-63-1304(b). If the commissioner rejects the RBC plan and it is revised by the insurer with or without the commissioner's recommendation, the plan is called the "revised RBC plan";

(14) "RBC report" means the report required under § 23-63-1303; and

(15) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus as determined according to the statutory accounting applicable to the annual financial statements required under § 23-63-216; and

(B) Other items, if any, that the RBC instructions may provide.

History. Acts 1995, No. 622, § 1; 1999, 2003, No. 1473, § 52; 2011, No. 760, § 4; No. 625, § 1; 2001, No. 1603, §§ 11, 12; 2015, No. 1223, §§ 20, 21.

23-63-1303. RBC reports.

(a) Annually on or before March 1, each domestic insurer shall prepare and submit to the Insurance Commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing the information as needed by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(1) With the NAIC according to the RBC instructions; and

(2) With the insurance commissioner in a state in which the insurer may do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report by the later of:

(A) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(B) The filing date.

(b) A life or accident and health insurer's or a fraternal benefit society's RBC is determined according to the formula stated in the RBC instructions. The formula shall take into account and may adjust for the covariance among the following factors determined in each case by applying the factors as stated in the RBC instructions:

(1) The risk for the insurer's assets;

(2) The risk of adverse insurance experience for the insurer's liabilities and obligations;

(3) The interest rate risk for the insurer's business; and

(4) Other business and relevant risks as determined in each case by applying RBC instructions.

(c) A property and casualty insurer's RBC is determined according to the formula stated in the RBC instructions. The formula may adjust for the covariance among the following factors determined according to the formula stated in the RBC instructions:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) Other business and relevant risks as stated in the RBC instructions.

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in this subchapter and the formulas, schedules, and instructions referenced in this subchapter are desirable in the business of insurance. Insurers should seek to maintain capital above the RBC levels needed by this subchapter. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this subchapter.

(e) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report".

History. Acts 1995, No. 622, § 1; 2001, No. 1603, § 13; 2011, No. 760, § 4; 2015, No. 1223, § 22.

23-63-1304. Company action level event — Definition.

(a) As used in this subchapter, "company action level event" means any of the following events:

(1) The filing of an RBC report by an insurer that indicates:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(B) If a life or accident and health insurer or a fraternal benefit society, the life or accident and health insurer or the fraternal benefit society has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and three (3) and has a negative trend; or

(C) For the year ending December 31, 2011, and each year following, if a property and casualty insurer, the property and casualty insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized

control level RBC and three (3) and triggers the trend test determined according to the trend test calculation included in the Property and Casualty RBC Instructions;

(2) The notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates an event in subdivision (a)(1) of this section, if the insurer does not challenge the adjusted RBC report under § 23-63-1308; or

(3) If under § 23-63-1308 an insurer challenges an adjusted RBC report that indicates the event in subdivision (a)(1) of this section, the notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that shall:

(1) Identify the conditions that contribute to the company action level event;

(2) Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event;

(3) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of and problems associated with the insurer's business, including without limitation its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(c) The insurer shall submit the RBC plan:

(1) Within forty-five (45) days after the company action level event; or

(2) If the insurer challenges an adjusted RBC report under § 23-63-1308, within forty-five (45) days after notification to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(d) Within sixty (60) days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer whether or not the RBC plan is implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall state the reasons for the determination and may state proposed revisions that shall make the RBC plan satisfactory in the judgment of the commissioner. On notification from the commissioner, the insurer shall prepare a revised RBC plan that may incorporate by reference revisions proposed by the commissioner and shall submit the revised RBC plan to the commissioner:

(1) Within forty-five (45) days after the notification from the commissioner; or

(2) If the insurer challenges the notification from the commissioner under § 23-63-1308, within forty-five (45) days after a notification to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner, subject to the insurer's right to a hearing under § 23-63-1308, may specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in a state in which the insurer may do business if:

(1) The state has an RBC provision substantially similar to § 23-63-1309(a); and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(A) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date that the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

History. Acts 1995, No. 622, § 1; 2001, No. 1603, § 14; 2011, No. 760, § 4; 2013, No. 1133, § 7; 2015, No. 1223, § 23.

23-63-1307. Mandatory control level event — Definition.

(a) As used in this subchapter, "mandatory control level event" means any of the following events:

(1) The filing of an RBC report that shows the insurer's total adjusted capital is less than its mandatory control level RBC;

(2) Notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates the event in subdivision (a)(1) of this section if the insurer does not challenge the adjusted RBC report under § 23-63-1308; or

(3) If under § 23-63-1308 the insurer challenges an adjusted RBC report that indicates the event in subdivision (a)(1) of this section, notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(b) In the event of a mandatory control level event:

(1)(A) For a life insurer or a fraternal benefit society, the commissioner shall take action to place the life insurer or the fraternal benefit society under regulatory control under § 23-68-101 et seq.

(B) In that event, the mandatory control level event is sufficient grounds for the commissioner to take action under § 23-68-101 et

seq., and the commissioner shall have the rights, powers, and duties to the life insurer or the fraternal benefit society stated in § 23-68-101 et seq.

(C) If the commissioner takes action under an adjusted RBC report, the life insurer or the fraternal benefit society is entitled to the protections of § 23-68-101 et seq. pertaining to summary proceedings.

(D) The commissioner may forego action for up to ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period; and

(2) With respect to a property and casualty insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under § 23-68-101 et seq., or in the case of an insurer that is writing no business and is running-off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event is sufficient grounds for the commissioner to take action under § 23-68-101 et seq., and the commissioner shall have the rights, powers, and duties with respect to the insurer stated in § 23-68-101 et seq. If the commissioner takes action under an adjusted RBC report, the insurer is entitled to the protections of § 23-68-101 et seq. pertaining to summary proceedings. The commissioner may forego action for up to ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

History. Acts 1995, No. 622, § 1; 2011, No. 760, § 4; 2015, No. 1223, § 24.

23-63-1310. Supplemental provisions — Rules — Exemption.

(a) This subchapter is supplemental to other laws of this state and does not preclude or limit other powers or duties of the Insurance Commissioner under those laws, including without limitation § 23-68-101 et seq.

(b) The commissioner may adopt reasonable rules necessary for the implementation of this subchapter.

(c) The commissioner may exempt a domestic insurer licensed to do business in this state from this subchapter if the domestic insurer:

- (1) Writes direct business only in this state;
- (2) Writes direct annual premiums of two million dollars (\$2,000,000) or less; and
- (3) Assumes no reinsurance more than five percent (5%) of direct premium written.

History. Acts 1995, No. 622, § 1; 1999, No. 625, § 2; 2001, No. 8, § 1; 2011, No. 760, § 4; 2015, No. 1223, § 25.

SUBCHAPTER 14 — DISCLOSURE OF MATERIAL TRANSACTIONS ACT

SECTION.

23-63-1402. Report.

23-63-1405. Rules.

23-63-1402. Report.

(a) Every insurer domiciled in this state shall file a report with the Insurance Commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information purposes pursuant to other provisions of the Arkansas Insurance Code, laws, rules, or other requirements.

(b) The report required in subsection A is due within fifteen (15) days after the end of the calendar month in which any of the foregoing transactions occur.

(c) One complete copy of the report, including any exhibits or other attachments, shall be filed with:

- (1) The insurance department of the insurer's state of domicile; and
- (2) The National Association of Insurance Commissioners.

(d) All reports obtained by or disclosed to the commissioner pursuant to this subchapter, shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the commissioner, the National Association of Insurance Commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer who would be affected notice and an opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by publication, in which event the commissioner may publish all or any part in the manner the commissioner may deem appropriate.

History. Acts 1995, No. 625, § 1; 2019, No. 315, § 2638.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (a).

23-63-1405. Rules.

The Insurance Commissioner may adopt reasonable rules for the implementation and administration of the provisions of this subchapter.

History. Acts 1995, No. 625, § 1; 2019, No. 315, § 2639.

deleted "and regulations" following "rules" in the section heading and in the text.

Amendments. The 2019 amendment

SUBCHAPTER 16 — LICENSING AND REGULATION OF CAPTIVE INSURERS

SECTION.

- 23-63-1601. Definitions.
- 23-63-1602. Application for license.
- 23-63-1604. Capital requirements.
- 23-63-1605. Surplus requirements.
- 23-63-1606. Organization.
- 23-63-1607. Reporting.
- 23-63-1610. Investments.
- 23-63-1611. Reinsurance.
- 23-63-1614. Premium tax — Definition.

SECTION.

- 23-63-1615. Rules.
- 23-63-1616. Limitations.
- 23-63-1619. [Repealed.]
- 23-63-1620. Sponsored captive insurance company — Requirements.
- 23-63-1621. Participants.
- 23-63-1624. Dormant captive insurance company — Definition.

Effective Dates. Acts 2013, No. 461, § 3: Mar. 21, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that Arkansas does not have a needed, competitive presence in the field of captive insurance companies and that this act will attract new captive insurance companies to the state; that a delay in permitting applications for new captive insurance companies will hurt the state's economy and cause an unnecessary burden on the Insurance Commissioner. Therefore, an

emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-63-1601. Definitions.

As used in this subchapter:

(1) "Affiliated company" means a company in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management;

(2) "Alien captive insurance company" means an insurance company formed to write insurance business for its parents and affiliates and licensed under the laws of an alien jurisdiction that imposes statutory or regulatory standards in a form acceptable to the Insurance Commissioner on companies transacting the business of insurance in the alien jurisdiction;

(3) "Association" means a legal association of individuals, corporations, partnerships, or associations that has been in continuous existence for at least one (1) year:

(A) The member organizations of which collectively, or which does itself:

(i) Own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer; or

(ii) Have complete voting control over an association captive insurance company incorporated as a mutual insurer; or

(B) The member organizations of which collectively constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer;

(4) "Association captive insurance company" means a company that insures risks of the member organizations of the association and their affiliated companies;

(5) "Branch business" means any insurance business transacted by a branch captive insurance company in this state;

(6)(A) "Branch captive insurance company" means an alien captive insurance company licensed by the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(B) A branch captive insurance company shall be a pure captive insurance company with respect to operations in this state unless permitted by the commissioner;

(7) "Branch operations" means any business operations of a branch captive insurance company in this state;

(8) "Captive insurance company" means a producer reinsurance captive insurance company, branch captive insurance company, pure captive insurance company, association captive insurance company, sponsored captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company formed or licensed under this subchapter;

(9) "Commissioner" means the Insurance Commissioner;

(10) "Controlled unaffiliated business" or "controlled unaffiliated entity" means a company:

(A) That is not in the corporate system of a parent and affiliated companies;

(B) That has an existing contractual relationship with a parent or affiliated company; and

(C) Whose risks are managed by a pure captive insurance company or participant in a sponsored captive insurance company;

(11) "Department" means the State Insurance Department;

(12) "General account" means all assets and liabilities of the sponsored captive insurance company not attributable to a protected cell;

(13) "Incorporated protected cell" means a protected cell that is established as a corporation or other legal entity separate from the sponsored captive insurance company or producer reinsurance captive insurance company of which it is a part;

(14)(A) "Industrial insured" means an insured:

(i) That procures insurance by use of the services of a full-time employee acting as a risk manager or insurance manager or utilizing the services of a regularly and continuously qualified insurance consultant;

(ii) Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars (\$25,000); and

(iii) That has at least twenty-five (25) full-time employees.

(B) "Industrial insured" does not mean "industrial life insurance" as used in § 23-82-101 et seq.;

(15)(A) "Industrial insured captive insurance company" means a company that insures risks of the industrial insureds that compose the industrial insured group and their affiliated companies.

(B) "Industrial insured captive insurance company" does not encompass "industrial life insurance" as used in § 23-82-101 et seq.;

(16)(A) "Industrial insured group" means a group that meets either of the following criteria:

(i) A group of industrial insureds that collectively:

(a) Own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer; or

(b) Have complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer; or

(ii) A group which is created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. § 3901 et seq., as it existed January 1, 2001, or the Risk Retention and Purchasing Groups Act, § 23-94-201 et seq., or as a corporation or other limited liability association taxable as a stock insurance company or a mutual insurer under the Arkansas Insurance Code.

(B) "Industrial insured group" does not encompass "industrial life insurance" as used in § 23-82-101 et seq.;

(17) "Member organization" means an individual, corporation, partnership, or association that belongs to an association;

(18) "Parent" means a corporation, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than fifty percent (50%) of the outstanding voting securities of a pure captive insurance company;

(19) "Participant" means an entity as defined in § 23-63-1621 and any affiliates of that entity that are insured by a sponsored captive insurance company when the losses of the participant are limited through a participant contract to the assets of a protected cell;

(20) "Participant contract" means a contract by which a sponsored captive insurance company insures the risks of a participant and limits the losses of the participant to the assets of a protected cell;

(21) "Producer reinsurance captive insurance company" means a company that is wholly owned by a licensed insurance producer and that acts only as a reinsurer for risks written by or placed through its parent or an affiliate of its parent;

(22) "Protected cell" means a separate account established and maintained by a sponsored captive insurance company for one (1) participant or by a producer reinsurance captive insurance company and includes an incorporated protected cell;

(23) "Pure captive insurance company" means a company that insures risks of its parent and affiliated companies or controlled unaffiliated business;

(24) "Special purpose captive insurance company" means a captive insurance company that is formed or licensed under this subchapter and does not meet the definition of any other type of captive insurance company defined in this section;

(25) "Sponsor" means an entity that meets the requirements of § 23-63-1620 and is approved by the commissioner to provide all or part of the capital and surplus required by applicable law and to organize and operate a sponsored captive insurance company; and

(26) "Sponsored captive insurance company" means a captive insurance company:

(A) In which the minimum capital and surplus required is provided by one (1) or more sponsors;

(B) That is formed or licensed under this subchapter;

(C) That insures the risks of separate participants through the contract; and

(D) That segregates each participant's liability through one (1) or more protected cells.

History. Acts 2001, No. 1391, § 1; 2003, No. 466, § 1; 2005, No. 506, § 30; 2017, No. 370, § 1; 2019, No. 521, § 5; 2021, No. 367, §§ 11, 12.

Amendments. The 2017 amendment substituted "shall" for "must" in (6)(B); inserted (12) and redesignated the remaining subdivisions accordingly; added "and includes an incorporated protected cell" at the end of (21); and made stylistic changes.

The 2019 amendment inserted "or 'controlled unaffiliated entity'" in (10); added

"or participant in a sponsored captive insurance company" in (10)(C); inserted (12); redesignated former (12) as (13) and redesignated the remaining subdivisions accordingly; and substituted "subchapter" for "chapter" in (24).

The 2021 amendment inserted "branch captive insurance company" in (8); and deleted "resident" preceding "licensed insurance producer" in (21).

23-63-1602. Application for license.

(a) When permitted by its organizational documents, a captive insurance company may apply to the Insurance Commissioner for a license to do all insurance, including workers' compensation insurance, authorized by the Arkansas Insurance Code. However:

(1) A pure captive insurance company shall not insure any risks other than those of its parent and affiliated companies or controlled unaffiliated business;

(2) An association captive insurance company shall not insure any risks other than those of the member organizations of its association and their affiliated companies;

(3) An industrial insured captive insurance company shall not insure any risks other than those of the industrial insureds that compose the industrial insured group and their affiliated companies;

(4) A captive insurance company shall not provide personal motor vehicle or homeowner's insurance coverage or any component of these coverages;

(5) A captive insurance company shall not accept or cede reinsurance except as authorized by § 23-63-1611;

(6) A producer reinsurance captive insurance company shall not reinsure any risks other than those written by or placed through its

parent or an affiliate of its parent and written by authorized insurers; and

(7) The following statement must appear on the front of every policy or certificate of insurance issued by a captive insurance company:

"THIS CONTRACT IS REGISTERED AND DELIVERED AS A POLICY UNDER ARKANSAS CODE § 23-63-1601 ET SEQ. THIS POLICY MAY BE DIFFERENT FROM POLICIES ISSUED IN THE OPEN MARKET. IT MAY BE MORE OR LESS FAVORABLE TO AN INSURED THAN A CONTRACT ISSUED BY AN INSURER NOT SUBJECT TO ARKANSAS CODE § 23-63-1601 ET SEQ. THE PROTECTION OF THE ARKANSAS PROPERTY AND CASUALTY INSURANCE GUARANTY ACT, ARKANSAS CODE § 23-90-101 ET SEQ., DOES NOT APPLY TO THIS CONTRACT."

(b) To conduct insurance business in this state, a captive insurance company shall:

(1) Be licensed to conduct insurance business in this state;

(2) Hold at least one (1) board of directors meeting, or in the case of a reciprocal insurer, a subscriber's advisory committee meeting, each year in this state;

(3) Maintain its registered office in this state, or in the case of a branch captive insurance company, maintain the registered office for its branch operations in this state; and

(4)(A) Appoint a resident registered agent to accept service of process and to act on its behalf in this state.

(B) In the case of a captive insurance company formed as a corporation or formed as a reciprocal insurer, the commissioner must be designated as the agent of the captive insurance company upon whom any process, notice, or demand may be served whenever the registered agent cannot, with reasonable diligence, be found at the registered office of the captive insurance company.

(c)(1) Before receiving a license, a captive insurance company:

(A) Formed as a corporation shall file with the commissioner:

(i) A certified copy of its articles of incorporation and bylaws;

(ii) A statement under oath of its president and secretary showing its financial condition; and

(iii) Any other statements or documents required by the commissioner; or

(B) Formed as a reciprocal shall:

(i) File with the commissioner:

(a) A certified copy of the power of attorney of its attorney in fact;

(b) A certified copy of its subscribers' agreement;

(c) A statement under oath of its attorney in fact showing its financial condition; and

(d) Any other statements or documents required by the commissioner; or

(ii)(a) Obtain the commissioner's approval of its coverages, deductibles, coverage limits, and rates.

(b) If there is a subsequent material change in an item in the description, the reciprocal captive insurance company shall submit to

the commissioner for approval an appropriate revision and may not offer any additional kinds of insurance until a revision of the description is approved by the commissioner.

(c) The reciprocal captive insurance company shall inform the commissioner of any material change in rates within thirty (30) days of the adoption of the change.

(2) In addition to the information required by subdivision (c)(1) of this section, a captive insurance company applying for a license shall file with the commissioner evidence of:

(A) The amount and description of its assets relative to the risks to be assumed;

(B) The adequacy of the expertise, experience, and character of the person or persons who will manage it;

(C) The overall soundness of its plan of operation;

(D) The adequacy of the loss-prevention programs of its parent, member organizations, or industrial insureds, as applicable; and

(E) Other factors considered relevant by the commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(3) In addition to the information required by subdivisions (c)(1) and (2) of this section, an applicant producer reinsurance captive insurance company or a sponsored captive insurance company shall file with the commissioner:

(A) A business plan demonstrating how the applicant will account for the loss and expense experience of each protected cell in as much detail as the commissioner may require, and the manner in which it will report the experience to the commissioner;

(B) A statement acknowledging that all financial records of the captive insurance company, including records pertaining to any protected cells, must be made available for inspection or examination by the commissioner; and

(C) Evidence that expenses will be allocated to each protected cell in an equitable manner.

(4) In addition to the information required by subdivisions (c)(1)-(3) of this section, a sponsored captive insurance company shall file with the commissioner all contracts between the sponsored captive insurance company and any participants.

(5) Information submitted under this subchapter is confidential and shall not be made public by the commissioner or an agent or employee of the commissioner without the written consent of the captive insurance company except that:

(A)(i) Information may be discoverable by a party in a civil action or contested case to which the captive insurance company that submitted the information is a party, upon a showing by the party seeking to discover the information that:

(a) The information sought is relevant to and necessary for the furtherance of the action or case;

(b) The information sought is unavailable from other nonconfidential sources; and

(c) A subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the commissioner.

(ii) However, subdivision (c)(4) of this section does not apply to an industrial insured captive insurance company insuring the risks of an industrial insured group; and

(B) The commissioner may disclose the information to a public official having jurisdiction over the regulation of insurance in another state if:

(i) The public official agrees in writing to maintain the confidentiality of the information; and

(ii) The laws of the state in which the public official serves require the information to be confidential.

(d)(1) A captive insurance company shall pay to the State Insurance Department Trust Fund a nonrefundable fee in an amount and manner to be prescribed by rule.

(2) The commissioner may retain legal, financial, and examination services from outside the State Insurance Department, the reasonable cost of which may be charged against the applicant.

(3) Section 23-61-208 applies to examinations, investigations, and processing conducted under the authority of this section.

(4) In addition, a captive insurance company shall pay to the fund a license fee for the year of registration and a renewal fee in an amount and manner to be prescribed by regulation.

(e) If the commissioner is satisfied that the documents and statements filed by the captive insurance company comply with this subchapter, the commissioner may grant a license authorizing the company to do insurance business in this state until March 1, at which time the license may be renewed.

History. Acts 2001, No. 1391, § 2; 2003, No. 466, § 2; 2017, No. 283, § 9; 2017, No. 370, § 2; 2019, No. 315, § 2640; 2021, No. 367, § 13.

Amendments. The 2017 amendment by No. 283 substituted “shall not” for “may not” in (a)(1) through (a)(6); and, in (a)(7), substituted “INSURER NOT SUBJECT TO ARKANSAS CODE § 23-63-1601 ET SEQ.” for “ADMITTED CARRIER” in the third sentence, and made stylistic changes.

The 2017 amendment by No. 370 substituted “organizational documents” for “articles of incorporation or charter” in the introductory language of (a).

The 2019 amendment substituted “rule” for “regulation” in (d)(1).

The 2021 amendment, in the introductory language of (c)(5), substituted “subchapter” for “subsection” and “shall” for “may” and inserted “captive insurance”; and substituted “official” for “officer” in the introductory language of (c)(5)(B).

23-63-1604. Capital requirements.

(a)(1) The Insurance Commissioner shall not issue a license to a producer reinsurance captive insurance company, pure captive insurance company, sponsored captive insurance company, association captive insurance company incorporated as a stock insurer, or industrial insured captive insurance company incorporated as a stock insurer unless the company possesses and maintains unimpaired paid-in capital of:

(A) In the case of a producer reinsurance captive insurance company, not less than three hundred thousand dollars (\$300,000);

(B) In the case of a pure captive insurance company, not less than one hundred thousand dollars (\$100,000);

(C) In the case of an association captive insurance company incorporated as a stock insurer, not less than four hundred thousand dollars (\$400,000);

(D) In the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than two hundred thousand dollars (\$200,000);

(E) In the case of a sponsored captive insurance company, not less than two hundred fifty thousand dollars (\$250,000); or

(F) In the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro formas, including the nature of the risks to be insured, but in no event less than three hundred thousand dollars (\$300,000).

(2) The capital may be in the form of:

(A) Cash;

(B) Other assets acceptable to the commissioner; or

(C) An irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System and approved by the commissioner.

(b)(1) The commissioner may prescribe additional capital based upon the type, volume, and nature of insurance business transacted.

(2) This capital may be in the form of:

(A) Cash;

(B) Other assets acceptable to the commissioner; or

(C) An irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System.

(c)(1) In the case of a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, the commissioner shall require that a trust fund, funded by an irrevocable letter of credit or other acceptable asset, be established and maintained in the United States for the benefit of United States policyholders and United States ceding insurers under insurance policies issued or reinsurance contracts issued or assumed by the branch captive insurance company through its branch operations.

(2)(A) The amount of the security may be no less than the capital and surplus required by this subchapter and the reserves on these insurance policies or reinsurance contracts, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses, and unearned premiums with regard to business written through branch operations.

(B)(i) The commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account required by this section by the same amount so long as the security remains posted with the reinsurer.

(ii) If the form of security selected is a letter of credit, the letter of credit must be issued by a bank chartered in this state or a member bank of the Federal Reserve System.

(d)(1) A captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus, in excess of the limitations set forth in § 23-63-515, without the prior approval of the commissioner.

(2) Approval of an ongoing plan for the payment of dividends or other distributions must be conditioned upon the retention, at the time of each payment, of capital or surplus in excess of amounts specified by or determined in accordance with formulas approved by the commissioner.

(3) This subsection (d) shall not apply to producer reinsurance captive insurance companies.

History. Acts 2001, No. 1391, § 4; (a)(1); and substituted “two hundred fifty thousand dollars (\$250,000)” for “five hundred thousand dollars (\$500,000)” in 2003, No. 466, § 3; 2019, No. 521, § 6.

Amendments. The 2019 amendment substituted “shall not issue” for “may not issue” in the introductory language of (a)(1)(E).

23-63-1605. Surplus requirements.

(a)(1) The Insurance Commissioner shall not issue a license to a captive insurance company unless the company possesses and maintains unimpaired surplus of:

(A) In the case of a producer reinsurance captive insurance company, not less than three hundred thousand dollars (\$300,000);

(B) In the case of a pure captive insurance company, not less than one hundred fifty thousand dollars (\$150,000);

(C) In the case of an association captive insurance company incorporated as a stock insurer, not less than three hundred fifty thousand dollars (\$350,000);

(D) In the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than three hundred thousand dollars (\$300,000);

(E) In the case of an association captive insurance company incorporated as a mutual insurer, not less than seven hundred fifty thousand dollars (\$750,000);

(F) In the case of an industrial insured captive insurance company incorporated as a mutual insurer, not less than five hundred thousand dollars (\$500,000);

(G) In the case of a sponsored captive insurance company, not less than two hundred fifty thousand dollars (\$250,000); and

(H) In the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro formas, including the nature of the risks to be insured, but in no event less than three hundred thousand dollars (\$300,000).

(2) The surplus may be in the form of:

(A) Cash;

(B) Other assets acceptable to the commissioner; or

(C) An irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System and approved by the commissioner.

(b) Notwithstanding the requirements of subsection (a) of this section, a captive insurance company organized as a reciprocal insurer under this subchapter may not be issued a license unless it possesses and maintains a free surplus of one million dollars (\$1,000,000).

(c)(1) The commissioner may prescribe additional surplus based upon the type, volume, and nature of insurance business transacted.

(2) This capital may be in the form of:

(A) Cash;

(B) Other assets acceptable to the commissioner; or

(C) An irrevocable letter of credit issued by a bank chartered by this state or a member bank of the Federal Reserve System.

(d)(1) A captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus in excess of the limitations set forth in § 23-63-515, without the prior approval of the commissioner.

(2) Approval of an ongoing plan for the payment of dividends or other distribution must be conditioned upon the retention at the time of each payment of capital or surplus in excess of amounts specified by or determined in accordance with formulas approved by the commissioner.

(3) This subsection (d) shall not apply to a producer reinsurance captive insurance company.

History. Acts 2001, No. 1391, § 5; 2003, No. 466, § 4; 2019, No. 521, § 7.

Amendments. The 2019 amendment substituted “shall not issue” for “may not issue” in the introductory paragraph of

(a)(1); and substituted “two hundred fifty thousand dollars (\$250,000)” for “five hundred thousand dollars (\$500,000)” in (a)(1)(G).

23-63-1606. Organization.

(a) A captive insurance company may be formed and operated in any form of business organization authorized under Arkansas law and approved by the Insurance Commissioner.

(b) The alien captive insurance company may register to do business in this state after the commissioner’s certificate has been issued.

(c) The capital stock of a captive insurance company incorporated as a stock insurer must be issued at not less than par value.

(d) At least one (1) of the members of the board of directors of a captive insurance company formed as a corporation in this state shall be a resident of the United States or a United States territory.

(e) At least one (1) of the members of the subscribers’ advisory committee of a captive insurance company formed as a reciprocal insurer shall be a resident of the United States or a United States territory.

(f)(1) A captive insurance company formed under this subchapter has the privileges of and is subject to the business organization law of this state and is subject to this subchapter.

(2) If a conflict occurs between business organization law and this subchapter, the latter controls.

(3)(A) The Arkansas Insurance Code concerning mergers, consolidations, mutualizations, and redomestications applies in determining the procedures to be followed by a captive insurance company in carrying out any of those transactions.

(B) The commissioner may, upon request of an insurer that is a party to a merger authorized under subdivision (f)(3)(A) of this section, waive certain applicable requirements to the merger transaction.

(C) A conversion may be accomplished under a reasonable plan and procedure as may be approved by the commissioner and according to rules that the commissioner may promulgate.

(D) The commissioner may waive or modify the requirements for public notice and hearing.

(E) If a notice of public hearing is required but no one requests a hearing, the commissioner may cancel the hearing.

(F) An alien insurer may be a party to a merger authorized under subdivision (f)(3)(A) of this section if the requirements for a merger between a captive insurance company and a foreign insurer under this chapter apply to the merger transaction.

(g)(1)(A) A captive insurance company formed as a reciprocal insurer under this subchapter is subject to § 23-70-101 et seq. and this subchapter.

(B) If a conflict occurs between § 23-70-101 et seq. and this subchapter, the latter controls.

(C) To the extent a reciprocal insurer is made subject to the Arkansas Insurance Code under § 23-70-101 et seq., the Arkansas Insurance Code is not applicable to a reciprocal insurer formed under this subchapter unless expressly made applicable to a captive insurance company by this subchapter.

(2) In addition to subdivision (g)(1) of this section, a captive insurance company organized as a reciprocal insurer that is an industrial insured group is subject to § 23-70-101 et seq. and applicable provisions of the Arkansas Insurance Code.

(h) The articles of incorporation or bylaws of a captive insurance company may authorize a quorum of a board of directors to consist of no fewer than one-third ($\frac{1}{3}$) of the fixed or prescribed number of directors under § 4-27-824(b).

(i) The subscribers' agreement or other organizing document of a captive insurance company formed as a reciprocal insurer may authorize a quorum of a subscribers' advisory committee to consist of no fewer than one-third ($\frac{1}{3}$) of the number of its members.

History. Acts 2001, No. 1391, § 6; 2003, No. 466, § 4; 2005, No. 1962, § 107; 2017, No. 370, § 3; 2019, No. 521, § 8.

Amendments. The 2017 amendment rewrote (a); deleted former (b) and (c) and redesignated the remaining subsections accordingly; substituted “shall” for “must” in (d) and (e); substituted “business orga-

nization” for “general corporation” in (f)(1) and (2); and made stylistic changes.

The 2019 amendment deleted “conversions” following “consolidations” in (f)(3)(A); redesignated former (f)(3)(B) as (f)(3)(D); redesignated former (f)(3)(C) as (f)(3)(E); and added (f)(3)(B), (f)(3)(C), and (f)(3)(F).

23-63-1607. Reporting.

(a) A captive insurance company shall not be required to make an annual report, except as provided under this subchapter.

(b)(1) Before March 1 of each year, or within an extension of time that, upon good cause shown, has been granted by the Insurance Commissioner, a captive insurance company shall submit to the commissioner a report of its financial condition, verified by oath of two (2) of its executive officers.

(2)(A) Except as provided in §§ 23-63-1604 and 23-63-1605, a captive insurance company shall report using generally accepted accounting principles unless the commissioner approves the use of statutory accounting principles.

(B) The commissioner may require, approve, or accept appropriate modifications or adaptations for the type of insurance and kinds of insurers to be reported upon, supplemented by additional information.

(3)(A) Unless provided otherwise, an association captive insurance company and an industrial insured group shall file their reports in the form required by § 23-63-216(a).

(B) The commissioner shall prescribe by rule the forms in which producer reinsurance captive insurance companies, pure captive insurance companies, and industrial insured captive insurance companies shall report.

(c) A producer reinsurance captive insurance company or a pure captive insurance company may apply to file the required report on a fiscal year-end that is consistent with the parent company’s fiscal year. If an alternative reporting date is granted:

(1) The annual report is due no later than sixty (60) days after the fiscal year-end; and

(2) In order to provide sufficient detail to support the premium tax return, the pure captive insurance company shall file before March 1 of each year for each calendar year-end pages one (1), two (2), three (3), and five (5) of the “Captive Annual Statement: Pure or Industrial Insured”, verified by oath of two (2) of its executive officers.

(d)(1) Sixty (60) days after the fiscal year-end, a branch captive insurance company shall file with the commissioner a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath by two (2) of its executive officers.

(2)(A) If the commissioner is satisfied that the annual report filed by the alien captive insurance company in its domiciliary jurisdiction

provides adequate information concerning the financial condition of the alien captive insurance company, the commissioner may waive the requirement for completion of the captive annual statement for business written in the alien jurisdiction.

(B) The waiver must be in writing and subject to public inspection.

History. Acts 2001, No. 1391, § 7; 2003, No. 466, § 6; 2009, No. 726, § 23; 2017, No. 370, § 4; 2019, No. 315, § 2641; 2019, No. 521, § 9.

Amendments. The 2017 amendment added “an association captive insurance company and an industrial insured group shall file their reports in the form required

by § 23-63-216(a)” in (b)(3)(A); and deleted (b)(3)(A)(i) and (b)(3)(A)(ii).

The 2019 amendment by No. 315 substituted “rule” for “regulation” in (b)(3)(B).

The 2019 amendment by No. 521 inserted “or within an extension of time if, upon good cause shown, has been granted by the Insurance Commissioner” in (b)(1).

23-63-1610. Investments.

(a)(1) Except as provided in § 23-63-1614, an association captive insurance company, a producer reinsurance captive insurance company, a sponsored captive insurance company, and an industrial insured group shall comply with the investment requirements contained in the Arkansas Insurance Code.

(2) The Insurance Commissioner may approve the use of alternative reliable methods of valuation and rating.

(b)(1) A pure captive insurance company or industrial insured captive insurance company is not subject to any restrictions on allowable investments contained in the Arkansas Insurance Code.

(2) The commissioner may prohibit or limit an investment that threatens the solvency or liquidity of the company.

(c)(1) Only a pure captive insurance company may make loans to its parent company or affiliates, with the prior written approval of the commissioner and evidenced by a note in a form approved by the commissioner.

(2) Loans of minimum capital and surplus funds required by § 23-63-1604(a) and § 23-63-1605(a) are prohibited.

(d) Notwithstanding the provisions of § 23-63-1620, the assets of two (2) or more protected cells may be combined for purposes of investment, and the combination does not defeat the segregation of such assets for accounting or other purposes.

(e)(1) Sponsored captive insurance companies shall comply with the investment requirements contained in § 23-63-801 et seq., as applicable.

(2) However, compliance with the investment requirements shall be waived for sponsored captive insurance companies to the extent that credit for reinsurance ceded to reinsurers is allowed under § 23-63-1611 or to the extent otherwise deemed reasonable and appropriate by the commissioner.

(f) Unless the commissioner requires or finds another method of valuation that is not inconsistent with the valuation method promulgated by the National Association of Insurance Commissioners and is

reasonable under the circumstances, the valuation procedures established by the National Association of Insurance Commissioners shall apply to sponsored captive insurance companies except to the extent the valuation procedures are inconsistent with approved accounting standards in use by the company.

(g) Notwithstanding any other provision of this subchapter, the commissioner may approve the use of alternative reliable methods of valuation and rating.

History. Acts 2001, No. 1391, § 10;
2019, No. 521, § 10.

Amendments. The 2019 amendment
added (d) through (g).

23-63-1611. Reinsurance.

(a) A captive insurance company may provide reinsurance under the Arkansas Insurance Code, on risks ceded by any other insurer.

(b) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers that are:

(1) Complying with § 23-62-305(a)-(d); or

(2) Not complying with § 23-62-305(a)-(d) upon approval of the captive insurance company's business plan by the Insurance Commissioner.

History. Acts 2001, No. 1391, § 11;
2013, No. 461, § 1.

23-63-1614. Premium tax — Definition.

(a) Except as provided in this section, a captive insurance company shall pay to the Insurance Commissioner by March 1 of each year, a tax at the rate of:

(1) Two hundred fifty thousandths of one percent (0.250%) on the first twenty million dollars (\$20,000,000);

(2) One hundred fifty thousandths of one percent (0.150%) on the next twenty million dollars (\$20,000,000); and

(3) Fifty thousandths of one percent (0.050%) on each dollar thereafter, on the direct premiums collected or contracted for on policies or contracts of insurance written by the captive insurance company during the year ending December 31 next preceding, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as return premiums, which shall include dividends on unabsorbed premiums or premium deposits returned or credited to policyholders.

(b)(1) Except as provided in this section, a captive insurance company shall pay to the commissioner by March 1 of each year, a tax at the rate of:

(A) Two hundred twenty-five thousandths of one percent (0.225%) on the first twenty million dollars (\$20,000,000) of assumed reinsurance premium;

(B) One hundred fifty thousandths of one percent (0.150%) on the next twenty million dollars (\$20,000,000);

(C) Fifty thousandths of one percent (0.050%) on the next twenty million dollars (\$20,000,000); and

(D) Twenty-five thousandths of one percent (0.025%) of each dollar thereafter.

(2) No reinsurance tax applies to premiums for risks or portions of risks that are subject to taxation on a direct basis under subsection (a) of this section.

(3) A premium tax is not payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control, if the transaction is part of a plan to discontinue the operations of the other insurer and if the intent of the parties to the transaction is to renew or maintain business with the captive insurance company.

(c) If the aggregate taxes to be paid by a captive insurance company calculated under subsections (a) and (b) of this section amount to less than five thousand dollars (\$5,000) in any year, the captive insurance company shall pay a tax of five thousand dollars (\$5,000) for that year.

(d) The total tax paid by a captive insurance company shall not exceed one hundred thousand dollars (\$100,000) in any year.

(e) A captive insurance company failing to make returns or to pay all taxes required by this section is subject to relevant sanctions under the Arkansas Insurance Code.

(f) Two (2) or more captive insurance companies under common ownership and control must be taxed as though they were a single captive insurance company.

(g) As used in this section, "common ownership and control" means:

(1) In the case of stock corporations, the direct or indirect ownership of eighty percent (80%) or more of the outstanding voting stock of two (2) or more corporations by the same shareholder or shareholders; and

(2) In the case of mutual corporations, the direct or indirect ownership of eighty percent (80%) or more of the surplus and the voting power of two (2) or more corporations by the same member or members.

(h) In the case of a branch captive insurance company, the tax under this section applies only to the branch business of the company.

(i)(1) The tax under this section constitutes all taxes collectible under the laws of this state from a captive insurance company.

(2) No other tax may be levied or collected from a captive insurance company by this state or a county, city, or municipality of this state, except ad valorem taxes on real and personal property used in the production of income.

(j) This section shall not apply to any producer reinsurance captive insurance company that invests and continuously maintains not less than fifty percent (50%) of its assets in certificates of deposit of any bank organized under the laws of the United States with a banking facility in the State of Arkansas or any federally insured bank or savings institution organized under the laws of the State of Arkansas, or in bonds, notes, warrants, or other securities, not in default, that are direct obligations of:

- (1) This state;
- (2) Any county, incorporated city or town, or duly organized school district or other taxing district of this state:

(A) If no default on the part of the obligor in payment of principal or interest on any of its obligations has occurred within five (5) years prior to the date of the proposed investment; or

(B) If the obligations were issued less than five (5) years prior to the date of investment, no default in payment of principal or interest has occurred on the obligations to be purchased or on any other public obligation of the obligor within five (5) years of the investment; or

- (3) Any local improvement district in this state to finance local improvements authorized by law, if the principal and interest of the obligations are payable from assessments on real property within the local improvement district, and:

(A) No default on the part of the obligor in payment of principal or interest on any of its obligations has occurred within five (5) years prior to the date of the proposed investment; or

(B) If the obligations were issued less than five (5) years prior to the date of investment, no default in payment of principal or interest has occurred on the obligations to be purchased or on any other public obligation of the obligor within five (5) years of the investment.

History. Acts 2001, No. 1391, § 14;
2003, No. 466, § 7; 2013, No. 461, § 2.

23-63-1615. Rules.

(a) The Insurance Commissioner may promulgate rules relating to captive insurance companies as are necessary to carry out this subchapter.

(b)(1) The commissioner may promulgate rules establishing standards to ensure that a parent or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by the pure captive insurance company or participant in a sponsored captive insurance company.

(2) Prior to these rules' being promulgated, the commissioner may grant, by temporary order, authority to a pure captive insurance company to insure risks.

History. Acts 2001, No. 1391, § 15;
2019, No. 315, § 2642; 2019, No. 521,
§ 11.

Amendments. The 2019 amendment by No. 315 substituted "rules" for "regulations" in the section heading, in (a), and in

(b)(1); and substituted "rules" for "regulations" in (b)(2).

The 2019 amendment by No. 521, in (b)(1), substituted "rules" for "regulations" and added "or participant in a sponsored captive insurance company".

23-63-1616. Limitations.

(a) The Arkansas Insurance Code does not apply to captive insurance companies except for those provisions contained in or specifically

referenced in this subchapter that are to be incorporated into the Arkansas Insurance Code.

(b) The Insurance Commissioner may exempt by rule or other order special purpose captive insurance companies on a case-by-case basis from the provisions of this chapter that he or she determines to be inappropriate, given the nature of the risks to be insured.

(c) In addition to this subchapter, the following provisions of the Arkansas Insurance Code and applicable rules apply to a risk retention group formed under the Risk Retention and Purchasing Groups Act, § 23-94-201 et seq., and subject to this subchapter:

(1) Section 23-61-201 et seq., and the Arkansas Credit for Reinsurance Law, § 23-62-301 et seq., referring to the commissioner;

(2) The Reinsurance Intermediary Act, § 23-62-401 et seq.;

(3) Sections 23-63-212 and 23-63-213, referring to certificates of authority;

(4) Section 23-63-216(e) and the Property and Casualty Actuarial Opinion Law, § 23-63-1901 et seq., referring to actuarial opinions;

(5) The Insurance Holding Company Regulatory Act, § 23-63-501 et seq., and § 23-69-129, referring to dividends to stockholders;

(6) Section 23-63-601 et seq., referring to financial reporting standards;

(7) Section 23-63-701, referring to limits of risk;

(8) Section 23-63-801 et seq., referring to investments;

(9) The Business Transacted with Producer Controlled Property and Casualty Insurer Act, § 23-63-1101 et seq., referring to producer controlled business;

(10) With the exception of § 23-63-1304(f) and § 23-63-1311, the Risk-Based Capital Act, § 23-63-1301 et seq., referring to risk-based capital;

(11) Section § 23-64-201 et seq., and the Producer Licensing Model Act, § 23-64-501 et seq., referring to licensure;

(12) The Managing General Agents Act, § 23-64-401 et seq., referring to managing general agents; and

(13) Section 23-68-101 et seq., and § 23-69-138, referring to impairment of capital or assets.

(d) If subsection (c) of this section is in conflict with this subchapter, subsection (c) of this section controls.

(e) Except as provided in this subchapter, the Risk Retention and Purchasing Groups Act, § 23-94-201 et seq., applies to a risk retention group formed as a captive insurer.

(f) In determining whether to take regulatory action under §§ 23-63-1304 — 23-63-1307, the commissioner may consider the adequacy of documentation evidencing the sound financial condition of the risk retention group's members or sponsoring organizations and intent to financially support the risk retention group, including:

(1)(A) A minimum of three (3) years of audited financial statements of the member or sponsor and one (1) year of projected financial information.

(B) The projected financial information required in subdivision (f)(1)(A) of this section shall include:

(i) An investment grade rating from a nationally recognized statistical rating organization or A.M. Best rating of A- or better;

(ii) Equity equal to or greater than one hundred million dollars (\$100,000,000); and

(iii) Equity equal to or greater than ten (10) times the risk retention group's largest net retained per occurrence limit; and

(2)(A) Policyholder qualification as an industrial insured in this state or the policyholder's home state, depending upon which state has the more stringent requirements.

(B) If the home state of the policyholder does not have an industrial insured exemption or its equivalent, the policyholder shall qualify under the industrial requirement of this state.

History. Acts 2001, No. 1391, § 16; by No. 315 deleted "regulation" following 2003, No. 466, § 8; 2019, No. 315, § 2643; "rule" in (b).
2019, No. 521, § 12. The 2019 amendment by No. 521 added

Amendments. The 2019 amendment (c) through (f).

23-63-1619. [Repealed.]

Publisher's Notes. This section, concerning conversions and mergers, was repealed by Acts 2019, No. 521, § 13, effective July 24, 2019. The section was derived from Acts 2001, No. 1391, § 19; 2009, No. 408, § 12; 2017, No. 370, §§ 5-7.

23-63-1620. Sponsored captive insurance company — Requirements.

(a) One (1) or more sponsors may form a sponsored captive insurance company under this subchapter.

(b)(1) A sponsor of a sponsored captive insurance company may be any person approved by the Insurance Commissioner, in his or her discretion, based on a determination that the approval of the person as a sponsor is consistent with the purposes of this section.

(2) In evaluating the qualifications of a proposed sponsor, the commissioner shall consider:

(A) The type and structure of the proposed sponsor entity;

(B) The experience in financial operations of the proposed sponsor entity;

(C) The financial stability and strength of the proposed sponsor entity;

(D) The business reputation of the proposed sponsor entity; and

(E) Other facts the commissioner deems relevant.

(c) In addition to the information required by § 23-63-1602, each applicant-sponsored captive insurance company shall file with the commissioner the following:

(1) Materials demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail

found to be sufficient by the commissioner, and how it will report the experience to the commissioner;

(2) A statement acknowledging that all financial records of the sponsored captive insurance company, including records pertaining to any protected cells, shall be made available for inspection or examination by the commissioner or his or her designee;

(3) All contracts or sample contracts between the sponsored captive insurance company and any participants; and

(4) Evidence that expenses shall be allocated to each protected cell in a fair and equitable manner.

(d) In his or her discretion, the commissioner may require that the business written by a sponsored captive insurance company, with respect to each protected cell, be:

(1) Fronted by an insurance company licensed under the laws of any state;

(2) Reinsured by a reinsurer authorized or approved by the commissioner; or

(3)(A) Secured by a trust fund in the United States for the benefit of policyholders and claimants or funded by an irrevocable letter of credit or other arrangement that is acceptable to the commissioner.

(B) The commissioner may require the sponsored captive insurance company to increase the funding of any security arrangement established under subdivision (d)(3)(A) of this section.

(C) If the form of security is a letter of credit, the letter of credit shall be issued or confirmed by a bank approved by the commissioner.

(D) A trust maintained under subdivision (d)(3)(A) of this section shall be established in a form and upon the terms approved by the commissioner.

(e) A risk retention group shall not be either a sponsor or a participant of a sponsored captive insurance company.

(f) A sponsored captive insurance company formed or licensed under this subchapter may establish and maintain one (1) or more protected cells to insure risks of one (1) or more participants, subject to the following conditions:

(1) The shareholders of a sponsored captive insurance company must be limited to its participants and sponsors;

(2) Each protected cell must be accounted for separately on the books and records of the sponsored captive insurance company to reflect the financial condition, results of operations of the protected cell, net income or loss, dividends or other distributions to participants, and other factors provided for in the participant contract or required by the commissioner;

(3) The assets of a protected cell must not be chargeable with liabilities arising out of any other insurance business the sponsored captive insurance company may conduct;

(4) No sale, exchange, or other transfer of assets may be made by the sponsored captive insurance company between or among any of its protected cells without the consent of the protected cells;

(5)(A) No sale, exchange, transfer of assets, dividend, or distribution may be made from a protected cell to a sponsor or participant without the commissioner's approval.

(B) In no event may the commissioner's approval be given if the sale, exchange, transfer, dividend, or distribution would result in insolvency or impairment with respect to a protected cell;

(6)(A) All attributions of assets and liabilities to the protected cells and the general account shall be according to the plan of operation approved by the commissioner.

(B) Other attribution of assets or liabilities shall not be made by a sponsored captive insurance company between its general account and a protected cell or between protected cells.

(C) The sponsored captive insurance company shall attribute all insurance obligations, assets, and liabilities relating to a reinsurance contract entered into with respect to a protected cell to the protected cell.

(D) The performance under the reinsurance contract and any tax benefits, losses, refunds, or credits allocated under a tax allocation agreement to which the sponsored captive insurance company is a party, including any payments made by or due to be made to the sponsored captive insurance company under the terms of the agreement, shall reflect the insurance obligations, assets, and liabilities relating to the reinsurance contract that are attributed to the protected cell;

(7) A sponsored captive insurance company shall file annually all the financial reports the commissioner requires, which shall include without limitation accounting statements detailing the financial experience of each protected cell;

(8) A sponsored captive insurance company shall notify the commissioner in writing within ten (10) business days of a protected cell that is insolvent or unable to meet its claim or expense obligations; and

(9)(A) No participant contract shall take effect without the commissioner's prior written approval.

(B) The addition of each new protected cell and the withdrawal of any participant of any existing protected cell constitute a change in the business plan requiring the commissioner's prior written approval.

(g) A protected cell of a sponsored captive insurance company may be formed as an incorporated protected cell subject to subsection (f) of this section and the following conditions:

(1)(A) Subject to the prior written approval of the sponsored captive insurance company and of the commissioner, an incorporated protected cell may enter into contracts and undertake obligations in its own name and for its own account.

(B) In the case of a contract or obligation to which the sponsored captive insurance company is not a party, either in its own name and for its own account or on behalf of a protected cell, the counterparty to the contract or obligation does not have a right or recourse against

the sponsored captive insurance company and its assets other than against assets properly attributable to the incorporated protected cell that is a party to the contract or obligation;

(2)(A) The articles of incorporation or articles of organization of an incorporated protected cell shall refer to the sponsored captive insurance company for which it is a protected cell and shall state that the protected cell is incorporated or organized for the limited purposes authorized by the sponsored captive insurance company's license.

(B) A copy of the prior written approval of the commissioner to add the incorporated protected cell shall be attached to and filed with the articles of incorporation or the articles of organization; and

(3) An incorporated protected cell shall have its own distinct name or designation, which shall include the words "Incorporated Cell".

(h)(1) A protected cell of a sponsored captive insurance company may be converted into an incorporated protected cell subject to the following conditions:

(A) Subject to the prior written approval of the commissioner, on application of the sponsor and with the prior consent of each participant of the affected protected cell or as otherwise permitted pursuant to a participation agreement, a sponsored captive insurance company may convert a protected cell into an incorporated protected cell without affecting the protected cell's assets, rights, benefits, obligations, and liabilities; and

(B) The conversion shall be deemed:

(i) For all purposes to be a continuation of the protected cell's existence together with all of its assets, rights, benefits, obligations, and liabilities, as an incorporated protected cell of the sponsored captive insurance company; and

(ii) To occur without any transfer or assignment of assets, rights, benefits, obligations, or liabilities and without the creation of any reversionary interest in, or impairment of, assets, rights, benefits, obligations, and liabilities.

(i) A protected cell of a sponsored captive insurance company may be sold, transferred, or assigned subject to the following conditions:

(1) Subject to the prior written approval of the commissioner, on application of the sponsor and with the prior consent of each participant of the affected protected cell, or as otherwise permitted under a participation agreement, or with the consent of the affected incorporated protected cell, a sponsored captive insurance company may sell, transfer, assign, and otherwise convey a protected cell or incorporated protected cell together with all of the protected cell's assets, rights, benefits, obligations, and liabilities to a new or existing sponsored captive insurance company, under a plan of operation that is approved by the commissioner;

(2) The sale, transfer, assignment, or conveyance is a continuation of the protected cell's existence together with all of its assets, rights, benefits, obligations, and liabilities, as a protected cell of the transferee; and

(3) The sale, transfer, assignment, or conveyance shall not be construed to limit any rights or protections applicable to the transferred protected cell or incorporated protected cell and the transferor sponsored captive insurance company that existed immediately before the sale, transfer, assignment, or conveyance.

(j) A protected cell of a sponsored captive insurance company may be converted to a new entity subject to the following conditions:

(1) Subject to the prior written approval of the commissioner, on application of the sponsor and with the prior consent of each participant in the affected protected cells or as otherwise permitted under a participation agreement and the consent of each affected incorporated protected cell, a sponsored captive insurance company may convert one

(1) or more protected cells or incorporated protected cells into a:

- (A) Single protected cell or incorporated protected cell;
- (B) New sponsored captive insurance company;
- (C) New pure captive insurance company;
- (D) New risk retention group;
- (E) New industrial insured captive insurance company; or
- (F) New association captive insurance company;

(2)(A) The conversion shall be subject to this section as well as to a plan of operation approved by the commissioner, without affecting any protected cell's or incorporated protected cell's assets, rights, benefits, obligations, and liabilities.

(B) The conversion is a continuation of each protected cell's or incorporated protected cell's existence together with all of its assets, rights, benefits, obligations, and liabilities, as a new protected cell or incorporated protected cell, a licensed sponsored captive insurance company, a pure captive insurance company, a risk retention group, an industrial insured captive insurance company, or an association captive insurance company, as applicable.

(C) The conversion shall occur without any transfer or assignment of assets, rights, benefits, obligations, or liabilities and without the creation of any reversionary interest in, or impairment of, assets, rights, benefits, obligations, and liabilities; and

(3) The conversion shall not be construed to limit any rights or protections applicable to any converted protected cell or incorporated protected cell and the sponsored captive insurance company, as applicable, that existed immediately before the date of the conversion.

(k)(1) Upon an order of supervision, rehabilitation, or liquidation of a sponsored captive insurance company, the receiver shall manage the assets and liabilities of the sponsored captive insurance company under this subsection.

(2) In connection with the conservation, rehabilitation, or liquidation of a sponsored captive insurance company, the assets and liabilities of a protected cell shall at all times be kept separate from, and shall not be commingled with, those of other protected cells and the sponsored captive insurance company.

(3) The assets of a protected cell shall not be used to pay any expenses or claims other than those attributable to the protected cell.

(4)(A) Unless the sponsor consents and the commissioner has granted prior written approval, the assets of the sponsored captive insurance company's general account shall not be used to pay any expenses or claims attributable solely to a protected cell of the sponsored captive insurance company.

(B) If the assets of the sponsored captive insurance company's general account are used to pay expenses or claims attributable solely to a protected cell of the sponsored captive insurance company, the sponsor is not required to contribute additional capital and surplus to the sponsored captive insurance company's general account, notwithstanding the provisions of §§ 23-63-1604 and 23-63-1605.

(5) A sponsored captive insurance company's capital and surplus shall at all times be available to pay any expenses of or claims against the sponsored captive insurance company.

(6) In the event of the insolvency of a sponsored captive insurance company in which the commissioner determines that one (1) or more protected cells remain solvent, the commissioner may separate the protected cells from the sponsored captive insurance company and, on application of the sponsor, may allow for the conversion of the protected cells into one (1) or more new or existing sponsored captive insurance companies, or one (1) or more other captive insurance companies, under a plan of operation approved by the commissioner.

(1)(1)(A) A creditor of a sponsored captive insurance company shall have recourse against the assets attributable to a protected cell only if it is a creditor of the protected cell.

(B) A creditor of a protected cell shall not be entitled to recourse against the assets attributable to another protected cell or to the assets in the sponsored captive insurance company's general account.

(2) When a sponsored captive insurance company has an obligation to a creditor arising from a transaction or otherwise imposed with respect to a protected cell, the obligation shall:

(A) Extend only to the assets attributable to that protected cell, and the creditor shall be entitled to recourse only against the assets attributable to that protected cell; and

(B) Not extend to the assets of another protected cell or to the assets in the sponsored captive insurance company's general account, and the creditor shall not be entitled to recourse against the assets attributable to another protected cell or to the assets of the sponsored captive insurance company's general account.

(3) When an obligation of a sponsored captive insurance company relates solely to its general account, a creditor shall have recourse only against the assets in the general account.

(4) The establishment of one (1) or more protected cells alone, and without more, shall not constitute or be deemed to be a fraudulent conveyance, an intent by the sponsored captive insurance company to defraud creditors, or the carrying out of business by the sponsored captive insurance company for any other fraudulent purpose.

(m) It is the intent of the General Assembly under this section to provide sponsored captive insurance companies with the option to establish one (1) or more protected cells as a separate legal entity.

(n) This section does not limit any rights or protections applicable to protected cells that are not established as separate legal entities.

History. Acts 2001, No. 1391, § 20; 2017, No. 370, §§ 8, 9; 2019, No. 521, § 14; 2021, No. 481, § 1.

Amendments. The 2017 amendment, in (c), substituted “In his or her discretion, the commissioner may require that the” for “The” and “with respect to each protected cell” for “must”; and added (f) and (g).

The 2019 amendment substituted “Sponsored captive insurance company — Requirements” for “Sponsorship requirements” in the section heading; rewrote (b); inserted (c) and redesignated the remaining subsections accordingly; rewrote (d);

substituted “shall not be either” for “may not be either” in (e); inserted (f)(6) and redesignated former (f)(6) through (f)(8) as (f)(7) through (f)(9); substituted “include without limitation accounting” for “include, but are not limited to, accounting” in (f)(7); substituted “subsection (f)” for “subsection (e)” in (g); substituted “The conversion” for “Any such conversion” in (h)(1)(B); deleted “any such” preceding “assets” twice in (h)(1)(B)(ii); added (i) through (l); and redesignated former (h)(2)(A) and (h)(2)(B) as (m) and (n).

The 2021 amendment inserted the second occurrence of “protected” in (k)(6).

23-63-1621. Participants.

(a) An association, corporation, limited liability company, partnership, trust, or other business entity may be a participant in a sponsored captive insurance company formed or licensed under this subchapter.

(b) A sponsor may be a participant in a sponsored captive insurance company.

(c) A participant need not be a shareholder of the sponsored captive insurance company or an affiliate of the company.

(d) A participant shall not insure any risks other than its own, its affiliated entities, or of controlled unaffiliated entities.

History. Acts 2001, No. 1391, § 21; 2019, No. 521, § 15.

Amendments. The 2019 amendment, in (d), inserted “not” and substituted “insure any risks other than its own, its

affiliated entities, or of controlled unaffiliated entities” for “insure only its own risks through a sponsored captive insurance company”.

23-63-1624. Dormant captive insurance company — Definition.

(a) As used in this section, “dormant captive insurance company” means a pure captive insurance company, sponsored captive insurance company, or industrial insured captive insurance company that has:

(1) Ceased transacting the business of insurance, including the issuance of insurance policies; and

(2) No remaining liabilities associated with insurance business transactions, or insurance policies issued before the filing of its application for a certificate of dormancy under this section.

(b)(1) A captive insurance company domiciled in this state that meets the criteria of subsection (a) of this section may apply to the Insurance Commissioner for a certificate of dormancy.

(2) The certificate of dormancy is subject to renewal every five (5) years and shall be forfeited if not renewed within that time.

(c) A dormant captive insurance company that has been issued a certificate of dormancy shall:

(1) Possess and thereafter maintain unimpaired, paid-in capital and surplus of not less than twenty-five thousand dollars (\$25,000);

(2) Before March 15 of each year, submit to the commissioner a report of its financial condition, verified by oath of two (2) of its executive officers, in a form as may be prescribed by the commissioner; and

(3) Pay a license renewal fee as provided in the rules promulgated by the commissioner under Section 18 of Rule and Regulation 73 of the State Insurance Department.

(d) A dormant captive insurance company is not subject to or liable for the payment of any tax under § 23-63-1614.

(e) A dormant captive insurance company shall apply to the commissioner for approval to surrender its certificate of dormancy and resume conducting the business of insurance before issuing any insurance policies.

(f) A certificate of dormancy shall be revoked if a dormant captive insurance company no longer meets the criteria of subsection (a) of this section.

(g) The commissioner may establish guidelines and procedures as necessary to carry out this section.

History. Acts 2017, No. 370, § 10.

SUBCHAPTER 17 — PROTECTED CELL COMPANY ACT

SECTION.

23-63-1705. Use and operation of protected cells.

23-63-1707. Conservation, rehabilitation, or liquidation of protected cell companies.

SECTION.

23-63-1709. Authority to adopt rules.

23-63-1705. Use and operation of protected cells.

(a)(1) The protected cell assets of a protected cell may not be charged with liabilities arising out of any other business the protected cell company may conduct.

(2) All contracts or other documentation reflecting protected cell liabilities shall clearly indicate that only the protected cell assets are available for the satisfaction of those protected cell liabilities.

(b)(1) The income, gains, and losses, realized or unrealized, from protected cell assets and liabilities shall be credited to or charged against the protected cell without regard to other income, gains, or losses of the protected cell company, including income, gains, or losses of other protected cells.

(2)(A) Amounts attributed to any protected cell and accumulations on the attributed amounts may be invested and reinvested without regard to any requirements or limitations of § 23-63-801 et seq.

(B) The investments in a protected cell or protected cells shall not be taken into account in applying the investment limitations applicable to the investments of the protected cell company.

(c) Assets attributed to a protected cell shall be valued at their fair value on the date of valuation.

(d)(1) A protected cell company, in respect to its protected cells, shall engage in fully funded indemnity triggered insurance securitization to support in full the protected cell exposures attributable to that protected cell.

(2) A protected cell company insurance securitization that is nonindemnity triggered shall qualify as an insurance securitization after the Insurance Commissioner adopts regulations addressing the methods of funding the portion of the risk that is not indemnity based, accounting, disclosure, risk-based capital treatment, and assessing risks associated with such securitizations.

(3) A protected cell company insurance securitization that is not fully funded, whether indemnity triggered or nonindemnity triggered, is prohibited.

(4)(A) Protected cell assets may be used to pay interest or other consideration on any outstanding debt or other obligation attributable to that protected cell.

(B) Nothing in this subsection shall prevent a protected cell company from entering into a swap agreement or other transaction for the account of the protected cell that has the effect of guaranteeing interest or other consideration.

(e)(1) In all protected cell company insurance securitizations, the contracts or other documentation effecting the transaction shall contain provisions identifying the protected cell to which the transaction will be attributed.

(2) The contracts or other documentation shall clearly disclose that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell.

(3) Failure to include the language required by this subsection in the contracts or other documentation shall not be used as the sole basis by creditors, reinsurers, or other claimants to circumvent the provisions of this subchapter.

(f)(1) A protected cell company shall be authorized to attribute to a protected cell account only the insurance obligations relating to the protected cell company's general account.

(2) A protected cell shall not be authorized to issue insurance or reinsurance contracts directly to policyholders or reinsureds or to have any obligation to the policyholders or reinsureds of the protected cell company's general account.

(g) At the cessation of business of a protected cell, the protected cell company shall voluntarily close out the protected cell account.

History. Acts 2001, No. 1428, § 5; inserted the second occurrence of “protected” in (b)(2)(B).
2021, No. 481, § 2.

Amendments. The 2021 amendment

23-63-1707. Conservation, rehabilitation, or liquidation of protected cell companies.

(a) Notwithstanding any provision of the Arkansas Insurance Code or any rule promulgated under the Arkansas Insurance Code or any other applicable law or rule, upon any order of conservation, rehabilitation, or liquidation of a protected cell company, the receiver shall be bound to deal with the protected cell company’s assets and liabilities, including protected cell assets and protected cell liabilities, in conformance with this subchapter.

(b) With respect to amounts recoverable under a protected cell company insurance securitization, the amount recoverable by the receiver shall not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to the protected cell company, notwithstanding any provision in the contracts or other documentation governing the protected cell company insurance securitization.

History. Acts 2001, No. 1428, § 7; substituted “rule” for “regulation” twice in 2019, No. 315, § 2644.

Amendments. The 2019 amendment

23-63-1709. Authority to adopt rules.

The Insurance Commissioner may promulgate rules necessary to carry out the purpose and intent of this subchapter.

History. Acts 2001, No. 1428, § 9; substituted “rules” for “regulations” in the 2019, No. 315, § 2645.

Amendments. The 2019 amendment

SUBCHAPTER 18 — AUDITS OF MEDICAL PROVIDERS

SECTION.

23-63-1801. Definitions.

23-63-1802. Time for recoupment.

23-63-1806. Rules.

SECTION.

23-63-1808. Application — Audit recoupment.

Effective Dates. Acts 2017, No. 815, § 13: Aug. 1, 2017. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that healthcare insurers and utilization review entities are denying medically necessary healthcare services; that by changing the prior authorization procedure to prevent the denial of medically necessary healthcare services by health-

care insurers and utilization review entities, Arkansas consumers will receive proper healthcare; and that unless this act becomes effective on August 1, 2017, utilization review entities and healthcare insurers will not know the specific effective date by which changes in computer systems must be made so that patients will not face the likelihood of going without potentially life-saving healthcare

treatment or their providers will not be forced to provide treatment without compensation. Therefore, an emergency is declared to exist, and this act being neces-

sary for the preservation of the public peace, health, and safety shall become effective on August 1, 2017.”

23-63-1801. Definitions.

As used in this subchapter:

(1) “Covered person” means a person on whose behalf a healthcare insurer offering health insurance coverage is obligated to pay benefits or provide services;

(2) “Healthcare insurer” means an entity subject to the insurance laws of this state or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization, or a hospital medical service corporation;

(3) “Healthcare provider” means any person or entity providing:

(A) Medical, pharmaceutical, optometric, or dental care;

(B) Hospitalization; or

(C) Any other services and goods used for the purpose or incidental to the purpose of preventing, alleviating, curing, or healing human illness or injury;

(4)(A) “Health insurance coverage” means benefits consisting of medical, pharmaceutical, optometric, or dental care, hospitalization, or other goods or services for the purpose of preventing, alleviating, curing, or healing human illness provided, directly or indirectly, through insurance, reimbursement, or otherwise, including items and services paid for under any policy, certificate, or agreement offered by a healthcare insurer.

(B) “Health insurance coverage” does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, Medicare supplemental policy as defined in 42 U.S.C. § 1395ss(g)(1), a specified disease, other limited benefit health insurance, automobile medical payment insurance, or claims under the Workers’ Compensation Law, § 11-9-101 et seq., Public Employee Workers’ Compensation Act, § 21-5-601 et seq., or the Comprehensive Health Insurance Pool Act, § 23-79-501 et seq.; and

(5) “Recoupment” means any action or attempt by a healthcare insurer to recover or collect payments already made to a healthcare provider with respect to a claim:

(A) By reducing other payments currently owed to the healthcare provider;

(B) By withholding or setting off the amount against current or future payments to the healthcare provider;

(C) By demanding payment back from a healthcare provider for a claim already paid; or

(D) By any other manner that reduces or affects the future claim payments to the healthcare provider.

History. Acts 2005, No. 422, § 1; 2019, No. 940, §§ 1, 2.

Amendments. The 2019 amendment substituted “Healthcare insurer” for

“Health care insurer” in (2); and substituted “Healthcare provider” for “Health care provider” in the introductory language of (3).

23-63-1802. Time for recoupment.

(a)(1) Except in cases of fraud committed by a healthcare provider, a healthcare insurer may exercise recoupment from a healthcare provider only during the eighteen-month period after the date that the healthcare insurer paid the claim submitted by the healthcare provider.

(2) A healthcare provider may submit a corrected claim for up to six (6) months after recoupment for services that were actually provided but billed in error without the intent to defraud.

(b)(1) A healthcare insurer that exercises recoupment under this section shall give the healthcare provider a written or electronic statement specifying the basis for the recoupment.

(2) At a minimum, the statement shall contain the information required by § 23-63-1804.

History. Acts 2005, No. 422, § 1; 2019, No. 940, § 3.

Amendments. The 2019 amendment added the (a)(1) designation; substituted

“a healthcare provider” for “the health care provider” in (a)(1); added (a)(2); and made stylistic changes.

23-63-1806. Rules.

The Insurance Commissioner shall adopt rules by January 1, 2006, to ensure compliance with this subchapter.

History. Acts 2005, No. 422, § 1; 2019, No. 315, § 2646.

Amendments. The 2019 amendment

deleted “and regulations” following “rules” in the section heading and in the text.

23-63-1808. Application — Audit recoupment.

The provisions of this subchapter that allow for audit recoupment from healthcare providers do not apply to a service that was authorized under § 23-99-1109, § 23-99-1113, or § 23-99-1116, except as provided for in § 23-99-1109(b).

History. Acts 2017, No. 815, § 1.

SUBCHAPTER 20 — CORPORATE GOVERNANCE ANNUAL DISCLOSURE ACT

SECTION.

23-63-2001. Title.

23-63-2002. Purpose — Intent.

23-63-2003. Definitions.

23-63-2004. Submission of corporate governance annual disclosure to Insurance Commissioner required.

SECTION.

23-63-2005. Corporate governance annual disclosure.

23-63-2006. Confidentiality.

23-63-2007. Third-party consultants.

23-63-2008. Penalties.

23-63-2009. Severability clause.

23-63-2010. Rules.

23-63-2001. Title.

This subchapter shall be known and may be cited as the "Corporate Governance Annual Disclosure Act".

History. Acts 2019, No. 521, § 16.

23-63-2002. Purpose — Intent.

(a) The purpose of this subchapter is to:

(1) Provide the Insurance Commissioner a summary of the corporate governance structure, policies, and practices of an insurer or insurance group to allow the commissioner an opportunity to gain and maintain a better understanding of the corporate governance framework of an insurer operating in this state;

(2) Outline the requirements for completing a corporate governance annual disclosure; and

(3) Provide assurance for the confidential treatment of the corporate governance annual disclosure and related information due to the confidential and sensitive information it will reveal as it relates to the internal operations and proprietary and trade secret information of an insurer or insurance group which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(b) It is the intent of the General Assembly that this subchapter:

(1) Not be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law;

(2) Not be construed to limit the commissioner's authority or the rights or obligations under § 23-61-201 et seq.; and

(3) Apply only to a multistate insurer domiciled in this state.

History. Acts 2019, No. 521, § 16; "Shall not"; and, in (b)(3), substituted "Apply only to a multistate insurer" for "Applies to an insurer".

Amendments. The 2021 amendment, in (b)(1) and (2), substituted "Not" for

23-63-2003. Definitions.

As used in this subchapter:

(1) "Corporate governance annual disclosure" means a confidential report filed by an insurer or insurance group made according to this subchapter;

(2) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in the Insurance Holding Company Regulatory Act, § 23-63-501 et seq.;

(3)(A) "Insurer" means a person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance.

(B) "Insurer" does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the

Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state; and

(4) "Person" includes an individual, insurer, company, association, organization, Lloyd's, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, and every legal entity.

History. Acts 2019, No. 521, § 16.

23-63-2004. Submission of corporate governance annual disclosure to Insurance Commissioner required.

(a)(1) On or before June 1 of each calendar year, an insurer, or the insurance group of which the insurer is a member, shall submit a corporate governance annual disclosure to the Insurance Commissioner.

(2) The corporate governance annual disclosure required under subdivision (a)(1) of this section shall contain the information described in § 23-63-2005.

(3) Notwithstanding any request from the commissioner made under subsection (c) of this section, if the insurer is a member of an insurance group, the insurer shall submit according to the laws of the lead state the corporate governance annual disclosure required under this section to the commissioner or regulator of the lead state for the insurance group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) A corporate governance annual disclosure shall include the signature of the chief executive officer or corporate secretary of the insurer or insurance group attesting that to the best of that individual's belief and knowledge the insurer has implemented the corporate governance practices and that a copy of the corporate governance annual disclosure has been provided to the insurer's board of directors or the appropriate committee.

(c) An insurer that is not required to submit a corporate governance annual disclosure under this section shall do so upon the request of the commissioner.

(d)(1) For purposes of completing the corporate governance annual disclosure, an insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance.

(2) The insurer or insurance group is encouraged to make the corporate governance annual disclosure filing at the level that:

(A) The insurer's or insurance group's risk appetite is determined;

(B) The earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively, and at which the supervision of those factors is coordinated and exercised; or

(C) Legal liability for failure of general corporate governance duties would be placed.

(3) When the insurer or insurance group determines the level of reporting based on the criteria described under subdivision (d)(2) of this section, the insurer or insurance group shall indicate which of the three (3) criteria described under subdivision (d)(2) of this section was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(e) The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(f) An insurer that provides information substantially similar to the information required by this subchapter in other documents that are submitted to the commissioner, including without limitation proxy statements filed in conjunction with Form B requirements or other state or federal filings that are provided to the State Insurance Department, shall not be required to duplicate that information in the corporate governance annual disclosure but is required to document and cross-reference the document that the relevant information is included in with the corporate governance annual disclosure.

History. Acts 2019, No. 521, § 16.

23-63-2005. Corporate governance annual disclosure.

(a)(1) The insurer or insurance group shall have discretion over the responses to the corporate governance annual disclosure inquiries or questions if the corporate governance annual disclosure contains the material information necessary to permit the Insurance Commissioner to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices.

(2) The commissioner may request additional information that he or she deems material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies.

(b) Notwithstanding subsection (a) of this section, the corporate governance annual disclosure shall be prepared consistent with any rule promulgated under § 23-63-2010.

(c) Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

History. Acts 2019, No. 521, § 16.

23-63-2006. Confidentiality.

(a) Documents, materials, or other information, including the corporate governance annual disclosure, in the possession or control of the

State Insurance Department and obtained by, created by, or disclosed to the Insurance Commissioner or any other person under this subchapter, is recognized by this state as being proprietary and containing trade secrets.

(b)(1) The information required under subsection (a) of this section:

(A) Is confidential by law and privileged and is not subject to:

(i) Public disclosure;

(ii) Subpoena; and

(iii) Discovery; and

(B) Is not admissible in evidence in any private civil action.

(2) The commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(3) The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(c) This section does not require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other corporate governance annual disclosure-related information under subsection (e) of this section to assist in the performance of the commissioner's regular duties.

(d) The commissioner or any person who receives documents, materials, or other corporate governance annual disclosure-related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom such documents, materials, or other information is shared under this subchapter shall not be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision (b)(2) of this section.

(e) In order to assist in the performance of the commissioner's regulatory duties, the commissioner may:

(1)(A) Upon request, share documents, materials, or other corporate governance annual disclosure-related information including the confidential and privileged documents, materials, or information subject to subsection (a) of this section, including proprietary and trade secret documents and materials, with:

(i) Other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in § 23-63-531;

(ii) The National Association of Insurance Commissioners; and

(iii) Third-party consultants under § 23-63-2007.

(B) In order to obtain information under subdivision (e)(1)(A) of this section, the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure-related documents, material, or other information and has verified in writing the legal authority to maintain confidentiality; and

(2)(A) Receive documents, materials, or other corporate governance annual disclosure-related information, including otherwise confiden-

tial and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from:

(i) Regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in § 23-63-531; and

(ii) The National Association of Insurance Commissioners.

(B) In order to obtain information under subdivision (e)(2)(A) of this section, the commissioner shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(f) The sharing of information and documents by the commissioner under this subchapter shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of this subchapter.

(g) A waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other corporate governance annual disclosure-related information shall not occur as a result of disclosure of any corporate governance annual disclosure-related information or documents to the commissioner under this section or as a result of sharing as authorized under this subchapter.

History. Acts 2019, No. 521, § 16.

23-63-2007. Third-party consultants.

(a) The Insurance Commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff, as may be reasonably necessary to assist the commissioner in reviewing the corporate governance annual disclosure and related information or the insurer's compliance with this subchapter.

(b) A person retained under subsection (a) of this section shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(c) The National Association of Insurance Commissioners and third-party consultants shall be subject to the same confidentiality standards and requirements as the commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it:

(1) Is free of a conflict of interest;

(2) Has internal procedures in place to monitor compliance with a conflict of interest; and

(3) Shall comply with the confidentiality standards and requirements of this subchapter.

(e) A written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided under this subchapter shall contain the follow-

ing provisions and require the written consent of the insurer before making public any information provided under this subchapter:

(1) Specific procedures and protocols for maintaining the confidentiality and security of corporate governance annual disclosure-related information shared with the National Association of Insurance Commissioners or the third-party consultant under this subchapter;

(2)(A) Procedures and protocols for sharing by the National Association of Insurance Commissioners only with other state regulators from states in which the insurance group has domiciled insurers.

(B) The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(3) A provision specifying that ownership of the corporate governance annual disclosure-related information shared with the National Association of Insurance Commissioners or the third-party consultant remains with the State Insurance Department and that the National Association of Insurance Commissioners' or third-party consultant's use of the information is subject to the direction of the commissioner;

(4) A provision that prohibits the National Association of Insurance Commissioners or the third-party consultant from storing the information shared under this subchapter in a permanent database after the underlying analysis is complete;

(5) A provision requiring the National Association of Insurance Commissioners or the third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's corporate governance annual disclosure-related information; and

(6) A requirement that the National Association of Insurance Commissioners or the third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or the third-party consultant may be required to disclose confidential information about the insurer that has been shared with the National Association of Insurance Commissioners or the third-party consultant under this subchapter.

History. Acts 2019, No. 521, § 16.

23-63-2008. Penalties.

(a) An insurer failing, without just cause, to timely file the corporate governance annual disclosure as required under this subchapter shall be required, after notice and hearing, to pay a penalty of one hundred dollars (\$100) for each day's delay, payable to the Insurance Commissioner, and the penalty recovered shall be paid into the General Revenue Fund Account of the State Apportionment Fund.

(b) The maximum penalty under subsection (a) of this section is ten thousand dollars (\$10,000).

(c) The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

History. Acts 2019, No. 521, § 16.

23-63-2009. Severability clause.

(a) Except for § 23-63-2007 or the application of § 23-63-2007 to any person or circumstance, if any provision of this subchapter is held invalid, the determination shall not affect the provisions of this subchapter that can be given effect without the invalid provision or application.

(b) With the exception of § 23-63-2007, this subchapter is severable.

History. Acts 2019, No. 521, § 16.

A.C.R.C. Notes. References in this section to § 23-63-2007 are likely in error. Pursuant to the NAIC model act from

which this subchapter is derived, the intended reference appears to be § 23-63-2006.

23-63-2010. Rules.

(a) The Insurance Commissioner shall promulgate rules necessary to implement this subchapter.

(b)(1) When adopting the initial rules to implement this subchapter, the final rule shall be filed with the Secretary of State for adoption under § 25-15-204(f):

(A) On or before January 1, 2020; or

(B) If approval under § 10-3-309 has not occurred by January 1, 2020, as soon as practicable after approval under § 10-3-309.

(2) The commissioner shall file the proposed rule with the Legislative Council under § 10-3-309(c) sufficiently in advance of January 1, 2020, so that the Legislative Council may consider the rule for approval before January 1, 2020.

History. Acts 2019, No. 521, § 16.

CHAPTER 64

LICENSEES, AGENTS, BROKERS, ADJUSTERS, AND CONSULTANTS

SUBCHAPTER.

1. GENERAL PROVISIONS.
2. LICENSING AND APPOINTMENT.
3. CONTINUING EDUCATION.
4. MANAGING GENERAL AGENTS ACT.
5. PRODUCER LICENSING MODEL ACT.
6. ARKANSAS HEALTH INSURANCE MARKETPLACE NAVIGATOR, GUIDE, AND CERTIFIED APPLICATION COUNSELORS ACT.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

23-64-102. Definitions.

23-64-102. Definitions.

As used in this chapter, unless the context otherwise requires:

(1)(A) An “agent” is an individual, firm, limited liability company, or corporation who is required by the Producer Licensing Model Act, § 23-64-501 et seq., to be licensed as an insurance producer by the Insurance Commissioner.

(B) An agent shall be deemed to be the agent of the appointing insurer;

(2)(A)(i) A “resident agent” is an agent whose residence is in or who may vote in this state or who is licensed as a resident insurance producer by the commissioner in accordance with the Producer Licensing Model Act, § 23-64-501 et seq.

(ii) Every reference herein to “an agent, a resident of this state” and to “a licensed agent, a resident of this state” shall include any duly licensed resident agent as defined in this section.

(B) By reciprocal arrangements with another state under which residents of Arkansas may be licensed and operate as resident agents of the other state, the commissioner may license, as resident agents of Arkansas, residents of the other state who:

(i) In cities or towns through which passes the Arkansas boundary, or border communities or border trade areas, maintain their principal place of business in that city, town, community, or trade area; and

(ii) Are otherwise qualified for the license.

(C) The terms “border communities” or “border trade areas” shall mean communities and trade areas situated within five (5) miles of the Arkansas boundary.

(D) Firms and corporations of which all the members and persons exercising the license power qualify individually as to residence under the definition in this subdivision (2) may be licensed as resident agents;

(3) A “broker” is an individual, firm, limited liability company, or corporation who is required to be licensed as an insurance producer under the Producer Licensing Model Act, § 23-64-501 et seq., who represents insureds or prospective insureds other than himself or herself or itself and not on behalf of an insurer or agent. A broker shall be deemed to be the agent of the insured;

(4)(A) An “adjuster” is an individual, firm, limited liability company, or corporation who for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates, on behalf of the insurer, settlement of claims arising under insurance contracts.

(B) A licensed attorney at law who is qualified to practice law in this state is not deemed to be an “adjuster” for the purposes of this chapter.

(C) A salaried employee of an insurer or of a managing general agent or of any adjustment bureau or association owned and maintained by insurers to adjust losses of member insurers is not deemed to be an "adjuster" for the purposes of this chapter.

(D) A resident agent or marine average adjuster or an agent or broker who adjusts or assists in adjustment of losses arising under policies procured through the broker or issued by the insurer represented by the agent that is appointed by the insurer shall not be deemed to be an "adjuster" for the purposes of this chapter.

(E)(i) The commissioner may issue "limited adjusters' licenses" to persons who are sponsored and are employees of self-insured, self-funded, entities for purposes of the adjustment of claims for or on the behalf of that self-insured sponsoring entity.

(ii) The limited license shall be valid only while the employee is employed by the sponsoring self-insured entity.

(iii) Qualifications, fees, and other aspects of licensure for "limited adjusters' licenses" shall be as established by regulation.

(F)(i) An individual who is an employee of or supervised by a licensed adjuster or agent who is exempt from licensure under subdivision (4)(D) of this section is not an adjuster if the individual, for purposes of portable electronic insurance claims:

- (a) Collects claim information from an insured and claimants;
- (b) Furnishes claim information to an insured or claimants; and
- (c) Conducts data entry through an automated claims adjudication system.

(ii) A single licensed adjuster or licensed agent shall not supervise more than twenty-five (25) persons under this subdivision (4)(F).

(iii) As used in this subdivision (4)(F), "automated claims adjudication system" means a preprogrammed computer system that is:

- (a) Designed for the collection, data entry, calculation, and resolution of portable electronics insurance claims;
- (b) Used only by:
 - (1) A licensed independent adjuster;
 - (2) A licensed agent; or
 - (3) A supervised individual operating under this chapter;
- (c) Compliant with all claim payment requirements of the insurance laws of this state; and

(d) Certified as compliant by a licensed independent adjuster;

(5)(A) An "insurance consultant" is an individual, firm, limited liability company, or corporation which, for a fee, in any manner advises or counsels anyone as to his or her insurance needs and coverages under any insurance policy or contract.

(B) The term "insurance consultant" shall not be deemed to include licensed attorneys, actuaries, certified public accountants, medical bill analysts, or any other person who gives or offers incidental advice to the public in the normal course of a business or professional activity other than insurance consulting; and

(6) For purposes of the commissioner's reciprocal arrangements or agreements with the insurance supervisory officials of other states for

licensure of nonresident insurance applicants as permitted in § 23-64-203 or other applicable laws, the term “insurance producer” means “agent” or “broker”, or both, as applicable, as defined in this section.

History. Acts 1959, No. 148, §§ 145-149, 151; A.S.A. 1947, §§ 66-2802 — 66-2806, 66-2808; Acts 1987, No. 622, § 1; 1987, No. 927, § 1; 1987, No. 955, § 1; 1997, No. 1004, § 1; 1999, No. 657, § 1; 2001, No. 580, § 3; 2013, No. 754, § 1.

SUBCHAPTER 2 — LICENSING AND APPOINTMENT

SECTION.

- 23-64-202. General qualifications for licensure — Exemptions — Definitions.
- 23-64-209. Qualifications for adjuster's license.
- 23-64-210. Licensing of adjuster and insurance consulting partnerships, limited partnerships, joint ventures, limited liability companies, and corporations.
- 23-64-216. Suspension or revocation.

SECTION.

- 23-64-219. Appointment of agent — Continuation or termination of appointment.
- 23-64-220. Place of business — Maintenance of records — Definition.
- 23-64-233. Limited license for self-service storage insurance — Definitions.
- 23-64-234. Travel insurance — Scope — Definitions — Licensing — Premium tax.

Effective Dates. Acts 2019, No. 698, § 4: “This act is effective for travel insurance sold on or after October 1, 2019.”

23-64-202. General qualifications for licensure — Exemptions — Definitions.

(a) For the protection of the people of this state, the Insurance Commissioner shall not, at or before completion of application processing, issue, continue, or permit to exist any license as to insurance unless the licensee is in compliance with this chapter and other applicable laws of this state, and as to any individual who does not also meet the following qualifications:

(1) To obtain a license as an agent or broker, he or she shall have complied with the Producer Licensing Model Act, § 23-64-501 et seq., and subsection (b) of this section; and

(2) To obtain a license as an adjuster or insurance consultant, he or she must be:

(A) Of legal age of majority or must have had disabilities of minority removed for all general purposes and provide evidence of same;

(B)(i) A resident of this state or of a city or town through which passes the boundary of this state, qualified as to residence under § 23-64-102(2)(B) and must have been a resident for not less than the

thirty (30) days immediately prior to the date of application for the license.

(ii) However, upon written request by the applicant, the commissioner in his or her discretion may waive the thirty-day residence requirement as to any applicant for license who is a bona fide resident of this state and who furnishes proof satisfactory to the commissioner that he or she is and intends to be a permanent resident of Arkansas; and

(C)(i) Deemed by the commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation, and these qualifications must continue in order to remain licensed.

(ii) On a case-by-case basis, the commissioner may require documentation to verify qualifications for licensure under this section.

(b) All applicants for a license as an agent, broker, adjuster, or insurance consultant shall:

(1) Pass a written examination for the license if required under this chapter and attest that he or she is familiar with the insurance laws of this state and will keep himself or herself familiar despite changes in the law; and

(2)(A)(i) Before licensure or examination, if examination is required, complete specific courses of instruction in the field of insurance as the commissioner shall by rule prescribe for the license.

(ii) Proof of completion must be presented before testing is administered.

(iii)(a) The courses of instruction shall consist, in the aggregate, of not less than twenty (20) hours of classroom instruction or electronic instruction per line of insurance authority. However, an applicant shall not be required to repeat the hours of instruction on Arkansas laws and rules within two (2) years of taking those hours for a previous line of authority.

(b) All instruction shall be administered by or under the supervision of persons qualifying with and approved by the commissioner for that purpose.

(c) An instructor deemed qualified and approved by the commissioner shall monitor attendance and participation and shall sign a certificate evidencing the licensee's completion of the hours.

(d) An applicant for an insurance consultant license is exempt from prelicensing education, as are nonresident applicants for producer and adjuster licenses from states that engage in reciprocal licensing with Arkansas.

(iv) Successful completion of the courses of instruction shall be certified to the commissioner, on forms prescribed by him or her, by the person under whose supervision the instruction was administered.

(v) The courses of instruction shall provide the applicant with basic knowledge of the broad principles of insurance, licensing, and regulatory laws of this state, and the obligations and duties of an agent, broker, or consultant.

(vi) Programs of instruction may be provided by any authorized insurer, agents' association, or trade association recognized by the commissioner or by any university, college, or any other institution in this state having a comprehensive course of instruction approved and certified by the commissioner.

(vii) The commissioner shall issue appropriate rules to implement the educational requirements and standards prescribed in this subdivision (b)(2) and to prescribe the general curriculum of courses of instruction.

(viii) The curriculum shall include not less than five (5) hours of instruction relative to the licensing of agents and insurance regulatory laws of this state, criteria for approval of the providers of the courses of instruction, and certifications contemplated hereunder.

(B) None of the provisions of this subsection shall apply to and no examination or educational requirements contained in this subsection shall be required of any applicant for a license presently exempted by law from an examination.

(C) The provisions of subdivision (b)(2)(A) of this section shall not apply to persons making application for license as an agent or broker for crop hail insurance, mobile home physical damage insurance, mortgagor's decreasing term life and disability insurance, prepaid legal insurance, and fire and marine insurance written in connection with credit transactions, or any line exempted by law, for which only a limited license is issued, nor any other insurance for which only a limited license may be issued and the commissioner, by order or regulation, exempts from the educational requirements of subdivision (b)(2)(A) of this section.

(c) No written examination shall be required for:

(1) Any applicant for a license as a limited line credit insurance producer as defined in § 23-64-502;

(2) Automobile dealers or automobile finance companies or their employees applying for licenses covering auto physical damage or the vendor's single interest on motor vehicles only;

(3) Limited lines travel insurance producers and their travel retailers;

(4) Applicants for licenses as nonresident agents or nonresident brokers, but subject to reciprocal arrangements as provided for in this chapter;

(5) Any applicant for a temporary license under this chapter;

(6) Applicants for licenses to sell credit property insurance;

(7)(A) Applicants for licenses to sell funeral expense insurance exclusively.

(B) "Funeral expense insurance" shall be defined in rules adopted by the commissioner;

(8) Applicants for licenses to sell mortgagor's decreasing term life insurance or mortgagor's decreasing term disability insurance to debtors of the applicants or of their employers; or

(9) Applicants for licenses to sell for farmers' mutual aid associations.

(d)(1) The commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance in connection with the rental of vehicles.

(2) As used in this subsection:

(A) "Limited license" means the authority of a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection;

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease;

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed ninety (90) days;

(D) "Rental period" means the term of the rental agreement;

(E) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed ninety (90) days; and

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and sport utility vehicles and of the cargo type, including cargo vans, pickup trucks, and trucks with a gross vehicle weight of less than twenty-six thousand pounds (26,000 lbs.) and that do not require the operator to possess a commercial driver's license.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the commissioner a written application for a limited license signed by an officer of the applicant, in such form or forms and supplements thereto, and containing such information as the commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the commissioner may:

(A) After notice and hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of law; or

(B) After notice and hearing, impose other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to this subsection may offer or sell insurance underwritten by a licensed insurer or authorized surplus lines carrier only in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection coverage in a master, corporate, group rental, or individual agreement in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle

occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance that at the exclusive option of the rental company may include uninsured and underinsured motorist coverage whether offered separately or in combination with other liability insurance that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other vehicle occupants for the loss of or damage to personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or auto-related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance may be issued by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed ninety (90) consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that the coverage offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and

(C) Evidence of coverage is disclosed within the rental agreement provided to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf of and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall conduct a training program in which employees being trained shall receive basic instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters

purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverages shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(e) [Repealed.]

History. Acts 1959, No. 148, § 153; 1975, No. 547, § 1; 1983, No. 522, §§ 10, 11; 1983, No. 534, §§ 1, 4, 5; A.S.A. 1947, §§ 66-2810, 66-2811.2, 66-2811.3; Acts 1987, No. 927, § 2; 1993, No. 523, § 1; 1993, No. 901, §§ 14-16; 1995, No. 592, § 1; 1997, No. 1004, § 1; 2001, No. 580, § 6; 2003, No. 1203, § 2; 2005, No. 1948, § 1; 2013, No. 1494, §§ 1, 2; 2019, No. 315, §§ 2647, 2648; 2019, No. 698, § 2; 2021, No. 397, § 1.

Amendments. The 2019 amendment by No. 315 substituted “rule” for “regula-

tion” in (b)(2)(A)(i); and substituted “rules” for “regulations” in (b)(2)(A)(vii).

The 2019 amendment by No. 698 repealed (e).

The 2021 amendment, in (b)(2)(A)(iii)(d), substituted “An applicant for an insurance consultant license is” for “Applicants for adjuster and consultant licenses are” and inserted “and adjuster”.

Effective Dates. Acts 2019, No. 698, § 4: “This act is effective for travel insurance sold on or after October 1, 2019.”

23-64-209. Qualifications for adjuster’s license.

(a) No person shall, in this state, act as or hold himself or herself out to be an adjuster unless then licensed therefor under this chapter. Application for license shall be made to the Insurance Commissioner according to forms as prescribed and furnished by him or her. The commissioner shall issue the adjuster’s license for property insurance, or for casualty insurance, or for workers’ compensation insurance, or for any combination thereof as to individuals qualified therefor upon payment of the nonrefundable license fee stated in § 23-61-401.

(b) To be licensed as an adjuster, the applicant must be qualified as follows:

(1) Must be of the legal age of majority, or have had the disabilities of minority removed for all general purposes and provide evidence of same;

(2)(A) Must be a resident of this state or licensed by another state that permits residents of this state to act as adjusters in the other state.

(B) A resident of another state or foreign country shall not be licensed as a nonresident independent adjuster in this state unless the person is licensed as an adjuster in another state;

(3) [Repealed.]

(4) Must be deemed by the commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation;

(5) Must have and maintain in this state an office accessible to the public and keep therein the usual and customary records pertaining to transactions under the license. This provision shall not be deemed to

prohibit maintenance of an office in the home of the licensee. A licensed, nonresident adjuster shall not be required to maintain an office in this state;

(6)(A)(i) Must pass a written examination as to his or her competence to act as a property, casualty, or workers' compensation insurance adjuster as shall be required by the commissioner.

(ii) The commissioner may give, conduct, and grade all examinations or he or she may arrange to have examinations administered and graded by an independent testing service as specified by contract, in a fair and impartial manner, and without unfair discrimination as between individuals examined.

(iii) The commissioner may require a waiting period of four (4) weeks before reexamination of an applicant who thrice failed to pass previous similar examinations. This waiting period applies after every third unsuccessful attempt.

(iv) The nonrefundable application fee shall be the same as that charged an applicant for license as an agent or broker under § 23-61-401.

(B)(i) If the application is approved and if the nonrefundable application fee is paid, an examination permit will be issued to the applicant.

(ii) The permit will be valid for a period of ninety (90) days from the date of issuance.

(iii) If the applicant does not schedule and appear for examination within that ninety-day period, the permit shall expire and the applicant may be required to file a new application and shall pay another nonrefundable application fee before issuance of another examination permit to the applicant.

(iv) If the applicant appears for examination but fails to pass such an examination, the applicant shall be required to pay a nonrefundable reexamination fee before reexamination.

(C) By reciprocal arrangements with the insurance supervisory official in the other state, the commissioner may waive written examination of a nonresident applicant for license as an adjuster, if the official certifies that the applicant is licensed as a resident adjuster of that state and has complied with its qualification standards therefor.

(c) A firm, limited liability company, or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers is named in the license and is qualified as for an individual licensed as adjuster. An additional full license fee shall be paid as to each individual in excess of one (1), so named in the license to exercise its powers.

(d)(1)(A) An adjuster who is sent into this state on behalf of an insurer for the purpose of investigating or making adjustment of a loss resulting from a catastrophe under an insurance policy is not required to be qualified or licensed under this section if within ten (10) business days of entering the state the adjuster notifies the

commissioner in writing of the adjuster's activities on behalf of the insurer.

(B) An adjuster shall cease and desist adjusting activity in this state within ninety (90) days of the notification described in subdivision (d)(1)(A) of this section or obtain an adjuster's license under this subchapter if otherwise required by the insurance laws of this state. (2)(A) An adjuster operating in this state under subdivision (d)(1)(A) of this section may request an additional ninety (90) days to obtain an adjuster's license in this state upon application for an extension to the commissioner.

(B) The commissioner has the discretion to approve a request for an extension described in subdivision (d)(2)(A) of this section.

(e)(1)(A) Unless exempt under subdivision (e)(2) of this section, a licensed adjuster shall successfully complete and report a minimum of twenty-four (24) hours of continuing education courses approved by the commissioner within the time established by rule of the commissioner.

(B) At least three (3) hours of continuing education required by this subsection shall be in an ethics course approved by the commissioner.

(2) This subsection does not apply to an adjuster licensed in:

(A) This state for less than one (1) year; or

(B) Another state if the adjuster has satisfied the continuing education requirements of the licensing state.

History. Acts 1959, No. 148, § 176; 2013, No. 754, § 2; 2015, No. 231, § 4; 1983, No. 522, § 21; 1985, No. 804, § 20; 2017, No. 283, § 10.
A.S.A. 1947, § 66-2833; Acts 1987, No. 622, §§ 15-17; 1997, No. 1004, § 1; 1999, No. 657, §§ 4, 5; 2009, No. 726, §§ 25-27; **Amendments.** The 2017 amendment redesignated former (d) as (d)(1)(A); and added (d)(1)(B) and (d)(2).

23-64-210. Licensing of adjuster and insurance consulting partnerships, limited partnerships, joint ventures, limited liability companies, and corporations.

(a)(1)(A) An adjusting or insurance consulting partnership, limited partnership, joint venture, limited liability company, or corporation may be licensed only as a licensee.

(B) If a partnership, limited partnership, or joint venture, each general partner and each other individual to act for it under the license, and if a limited liability company or a corporation, each individual to act for it under the license, shall be named in the license and shall qualify for the license as though an individual licensee.

(2) The Insurance Commissioner shall charge, and the licensee shall pay, a full additional license fee as to each respective individual so named in the license in excess of one (1) licensee.

(b)(1) The commissioner in his or her discretion may issue a license to a partnership, limited partnership, joint venture, limited liability company, or corporation organized under the laws of another state if the partnership, limited partnership, joint venture, limited liability com-

pany, or corporation is licensed as a resident licensee under the laws of its state of domicile.

(2)(A) Each individual authorized to act on behalf of a partnership, limited partnership, joint venture, limited liability company, or corporation under the license shall be named in the license and shall qualify therefor as though an individual licensee under the provisions of the Arkansas Insurance Code.

(B) The commissioner shall charge, and the licensee shall pay, a full additional license fee as to each respective individual licensee in the license in excess of one (1), in the amounts stated in § 23-61-401 and any existing or future rule.

(3) The nonresident licensee shall promptly notify the commissioner of all changes among its members, partners, directors, managers, and officers, and all other individuals designated in the license.

(c) Within ten (10) days, each licensee shall notify the commissioner of all changes among its members, directors, officers, and all other individuals designated in the license.

(d)(1) Every firm, limited liability company, or corporation licensed and every applicant for a license shall file with the commissioner the true name of the firm, limited liability company, or corporation and also all fictitious names under which it conducts or intends to conduct its business and, after licensing, shall file with the commissioner any change in or discontinuance of those names.

(2) The commissioner may disapprove in writing the use of any name on any of the following grounds:

(A) The name is identical to or is similar to that of another licensee so as to confuse or otherwise mislead the public;

(B) The name includes words or phrases that may mislead the public as to activities not authorized under the license or which are in violation of any insurance law or insurance regulation;

(C) The name states, infers, or implies that the firm, limited liability company, or corporation is an insurer, motor club, or hospital service plan or entitled to engage in insurance activities not permitted under the license applied for or held; or

(D) Other reasonable grounds as the commissioner may determine.

(3) The grounds specified in subdivisions (d)(2)(B) and (d)(2)(D) of this section shall not be applicable to the true name of any firm or corporation which on March 21, 1985, held a license issued under this subchapter.

(e) In the event an insurer does not wish to provide for the authority of all such agents authorized under the license of a partnership, limited partnership, joint venture, limited liability company, or corporation to act on their behalf, that insurer may appoint specific agents individually within it, and they may act on the behalf of the insurer, but only:

(1) While acting on the behalf of the partnership, limited partnership, joint venture, limited liability company, or corporation; and

(2) If among those specific agents individually appointed, there is one (1) general partner, one (1) officer of the corporation, or one (1) manager of the limited liability company or joint venture.

(f) Every partnership, limited partnership, joint venture, limited liability company, or corporation receiving a license pursuant to this section, shall designate and continuously maintain in the state:

(1) A registered office that may be the same as any of its places of business; and

(2) A registered agent, who may be:

(A) An individual who resides in this state and whose business office is identical with the registered office;

(B) A state bank, domestic corporation, or not-for-profit corporation whose business office is identical with the registered office; or

(C) A foreign corporation or foreign not-for-profit corporation authorized to transact business in this state whose business office is identical with the registered office.

(g)(1) The partnership, limited partnership, joint venture, limited liability company, or corporation may change its registered office or registered agent by delivering to the commissioner for filing a statement of change that sets forth:

(A) Its name;

(B) The street address of its current registered office;

(C) If the current registered office is to be changed, the street address of its new registered office;

(D) The name of its current registered agent;

(E) If the current registered agent is to be changed, the name of its new registered agent with the new agent's written consent to the appointment, either on the statement or attached to it; and

(F) That after the change or changes are made, the street addresses of its registered office and the business office of its reciprocal agent will be identical.

(2) If a registered agent changes the street address of the registered agent's business office, he or she may change the street address of the registered office of any foreign insurer holding a certificate of authority to transact business in Arkansas or any domestic reciprocal insurer for which he or she is the registered agent by:

(A) Notifying the insurer in writing of the change; and

(B) Signing, either manually or in facsimile, and delivering to the commissioner for filing a statement of change that:

(i) Complies with the requirements of subsection (a) of this section; and

(ii) Recites that the insurer has been notified of the change.

(h)(1) The registered agent of a partnership, limited partnership, joint venture, limited liability company, or corporation, holding a license under this section, may resign his or her agency appointment by signing and delivering to the commissioner for filing the original and two (2) exact or conformed copies of a statement of resignation. The statement of resignation may include a statement that the registered office is also discontinued.

(2) After filing the statement, the commissioner shall attach the filing receipt to one (1) copy and mail the copy and receipt to the registered office if not discontinued. The commissioner shall mail the other copy to the partnership, limited partnership, joint venture, limited liability company, or corporation at its principal office address shown in its most recent annual report.

(3) The agency appointment is terminated, and the registered office discontinued if so provided, on the thirty-first day after the date on which the statement was filed.

(i)(1) The registered agent of a partnership, limited partnership, joint venture, limited liability company, or corporation holding a license issued pursuant to this section in Arkansas is the insurer's agent for service of process, notice, or demand required or permitted by law to be served on it.

(2) A partnership, limited partnership, joint venture, limited liability company, or corporation may be served by registered or certified mail, return receipt requested, addressed to its managing partner, manager, president, or secretary at its principal office shown in its application for a license if it:

(A) Has no registered agent or its registered agent cannot with reasonable diligence be served;

(B) Has withdrawn from transacting business in this state; or

(C) Has had its license revoked under this subchapter.

(3) Service is perfected at the earliest of:

(A) The date the insurer receives the mail;

(B) The date shown on the return receipt, if signed on behalf of the insurer; or

(C) Five (5) days after its deposit in the United States mail, as evidenced by the postmark, if mailed postpaid and correctly addressed.

(4) This section does not prescribe the only means or necessarily the required means of serving a partnership, limited partnership, joint venture, limited liability company, or corporation holding a license under this section.

History. Acts 1959, No. 148, § 155; § 1; 1997, No. 1004, § 1; 2001, No. 580, 1983, No. 522, §§ 13, 14; 1985, No. 484, § 13; 2019, No. 315, § 2649.

§§ 1, 2; A.S.A. 1947, §§ 66-2812, 66-2812.1, 66-2812.2; Acts 1987, No. 456, 1987, No. 622, § 3; 1991, No. 1143, in (b)(2)(B). **Amendments.** The 2019 amendment deleted "and regulation" following "rule"

23-64-216. Suspension or revocation.

(a) The Insurance Commissioner may suspend for up to thirty-six (36) months, may revoke or refuse to continue, or may place in probationary status any license issued by him or her if after notice to the licensee and after hearing, unless a hearing is exempted under subdivision (a)(2)(I)(iii) of this section, he or she finds any one (1) or more of the following causes exist:

(1) In the case of an insurance producer or broker licensed as an insurance producer, for any of the causes under § 23-64-512; or

(2) In the case of an adjuster or insurance consultant licensed under this subchapter:

(A) Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

(B) Violating any insurance laws or violating any regulation, subpoena, or order of the Insurance Commissioner or of another state's insurance commissioner;

(C) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(D) Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing insurance business;

(E) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(F) Having been convicted of a felony;

(G) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(H) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere;

(I)(i) Having an insurance producer, insurance consultant, or adjuster license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory.

(ii) A license of a nonresident insurance producer, adjuster, or insurance consultant whose home state license ceases to be active shall be summarily suspended by the Insurance Commissioner under § 23-64-508(b)(2).

(iii)(a) If summarily suspending the license of a nonresident insurance producer, adjuster, or insurance consultant under subdivision (a)(2)(I)(ii) of this section, the Insurance Commissioner shall provide notice in writing to the address provided to the State Insurance Department by the licensee.

(b) The notice required under subdivision (a)(2)(I)(iii)(a) of this section shall inform the licensee that a hearing may be requested within thirty (30) days of receipt of the notice of suspension;

(J) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(K) Improperly using notes or any other reference material to complete an examination for an insurance license;

(L) Knowingly accepting insurance business from an individual who is not licensed;

(M) Failing to comply with an administrative or court order imposing a child support obligation; or

(N) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(b) For purposes of this section, licenses also include permits, registrations, or certificates of authority.

(c) The license of a firm, limited liability company, or corporation may be suspended, revoked, or refused also for any of such causes as relate to any individual designated in the license to exercise its powers.

(d)(1) If the commissioner finds that one (1) or more grounds exist for the suspension or revocation of any license, the commissioner in his or her discretion may impose upon the licensee an administrative penalty in the amount of up to one thousand dollars (\$1,000) per violation or, if the commissioner has found willful misconduct or willful violation on the part of the licensee, up to five thousand dollars (\$5,000) per violation.

(2) The administrative penalty may be augmented, in the commissioner's discretion, by an amount equal to any commissions received by or accruing to the credit of the licensee for any transaction related to the proceeding against the licensee.

(3) The commissioner may also order restitution of actual losses to affected persons.

(e)(1) If the commissioner determines that the public health, safety, or welfare imperatively requires emergency action and incorporates a finding to that effect in his or her order, pending an administrative hearing, the commissioner may:

(A) Issue a summary suspension of any license issued by him or her; or

(B) Issue an emergency cease and desist order.

(2) A hearing held under this subsection shall be promptly instituted.

(f)(1) If upon notice and hearing the commissioner finds that the licensee has violated a provision of the insurance laws of this state or any rule or order of the commissioner and that the licensee previously has been found to have violated provisions of the insurance laws of this state or any rule or order of the commissioner, by an order of the commissioner after hearing or by an order entered with the consent and agreement of the parties, the commissioner may take judicial notice of the previous orders against the licensee and, within the commissioner's discretion, may enhance or increase the penalties ordered in the current proceeding as to the licensee, and the commissioner shall incorporate a finding to that effect in his or her order.

(2) Statutory or regulatory violations for which an order has been entered as to the licensee by the insurance department or equivalent regulatory body in any other jurisdiction may be taken into consideration and included in assessing the enhanced or increased penalties provided in subdivision (f)(1) of this section.

(g) The penalties recited in this section may be imposed by the commissioner for violations of the Arkansas Insurance Code or other applicable laws, or rules or orders of the commissioner, committed by any resident agent whose license is on inactive or retired status.

(h) For purposes of this section, "probationary status" means the suspended imposition of insurance license sanctions that the commissioner may impose by law or by informed consent on a licensee subject

to this chapter, upon disclosed terms and for a specified period, contingent upon the compliance and good conduct of the licensee during that period, and that would result in imposition of insurance license sanctions upon the licensee's failure to successfully complete the specified period.

History. Acts 1959, No. 148, § 178; 1973, No. 66, § 6; 1983, No. 522, § 22; A.S.A. 1947, § 66-2835; Acts 1987, No. 622, § 19; 1993, No. 901, § 26; 1997, No. 1004, § 1; 2001, No. 580, § 19; 2003, No. 1203, §§ 3, 4; 2011, No. 760, § 6; 2019, No. 315, § 2650; 2021, No. 397, § 2.

Amendments. The 2019 amendment deleted "regulation" following "rule" twice in (f)(1).

The 2021 amendment inserted "unless a hearing is exempted under subdivision (a)(2)(I)(iii) of this section" in the introductory language of (a); substituted "Insurance Commissioner" for "commissioner" in (a)(2)(B); and added (a)(2)(I)(ii) and (a)(2)(I)(iii) and redesignated former (a)(2)(I) as (a)(2)(I)(i).

23-64-219. Appointment of agent — Continuation or termination of appointment.

(a)(1)(A) Each insurer appointing an agent in this state shall file with the Insurance Commissioner the initial agent appointment and pay the fee.

(B) The appointment means the notification filed with the commissioner that an insurer has established an agency relationship with a producer.

(2) The appointing insurer's appointment of an agent shall be an indication to the commissioner that the insurer has reviewed the agent's background and fitness to be an agent.

(b) Each appointment shall remain in effect until the agent's license is revoked or otherwise terminated unless written notice of earlier termination of the appointment is filed with the commissioner by the insurer or agent.

(c)(1) Biennially, prior to June 1 of each even-numbered year, each insurer maintaining a certificate of authority to transact life and accident and health insurance and, prior to June 1 of each odd-numbered year, all other insurers maintaining a certificate of authority to transact insurance in this state shall file with the commissioner an alphabetical list of the names and addresses of all its agents whose appointments in this state are to remain in effect, accompanied by payment of the biennial continuation of appointment fee as provided in § 23-61-401. At the same time, the insurer shall also file with the commissioner an alphabetical list of the names and addresses of all its agents whose appointments in this state are not to remain in effect, accompanied by any documentation the commissioner shall require.

(2) The procedures for renewal and termination of appointments under this subsection shall terminate on December 31, 2003.

(d) Beginning January 1, 2004, the following annual procedures apply for appointment terminations and renewals only:

(1)(A) No later than June 1, 2004, and no later than June 1 annually thereafter, while maintaining a certificate of authority to transact

insurance in the state, the insurance company shall terminate any appointments the company does not desire to continue by use of written or electronic notice to the commissioner on forms prescribed by the commissioner.

(B) The terminations shall be transmitted after the insurer reviews its own agent or agency appointments via the State Insurance Department website, the National Association of Insurance Commissioners' producer database, or a list requested of the department's Information Systems Division;

(2)(A) After June 1, 2004, and after June 1 annually thereafter, the department shall issue a written or electronic payment invoice to the insurer, based on all agent appointments the insurer chose to renew and keep active after June 1, 2004, and annually thereafter, in the procedures set out in subdivision (d)(1) of this section.

(B) The invoice under this section may not be altered, amended, or used for appointing or terminating producers;

(3)(A) The insurer shall return monetary payment for the department invoices to the commissioner no later than thirty (30) days after the department issues the invoice unless, at the request of the appointing insurer, the commissioner grants an extension for good cause in writing.

(B) An insurer's failure to remit timely invoice payments in the correct amount may be penalized by the commissioner with a monetary penalty in an amount not to exceed double the appointment fee; and

(4)(A) If the insurer disagrees with the annual invoice amount for the renewed agent appointments, it shall timely remit the invoice amount to the department but may mail or electronically mail under separate cover adequate documentation to substantiate its proposed invoice for the department's review.

(B) If the insurer underpaid, it shall promptly remit the monetary balance due the department.

(C) If the insurer overpaid, it shall so state in a written filing to the commissioner.

(D) If the department determines that the insurer is correct as to the overpayment amount, the department shall process a refund of the excess fees to the prevailing insurer.

(E) However, if the department determines the insurer is not correct, then the department may issue a written notice to the insurer.

(e) The insurer shall give notice, in any written or electronic method prescribed by the commissioner, of nonrenewal or termination of agent or producer appointments to the commissioner and to the producer and shall retain the notices or electronic transmittals as part of the insurer's records for compliance under this section and under § 23-64-515.

History. Acts 1959, No. 148, § 160; 1973, No. 66, § 4; 1983, No. 522, § 20; A.S.A. 1947, § 66-2817; Acts 1987, No. 622, § 9; 1991, No. 487, § 1; 1993, No. 901, § 28; 1997, No. 1004, § 1; 2001, No. 1603, §§ 16, 17; 2003, No. 1203, § 6; 2019, No. 521, § 17.

Amendments. The 2019 amendment substituted “initial agent appointment and pay the fee” for “initial appointment setting out the kinds of insurance to be transacted by the agent and pay the fee” in (a)(1)(A).

23-64-220. Place of business — Maintenance of records — Definition.

(a)(1) Every resident agent or resident broker shall have and maintain in this state, or in a city or town in another state through which passes the boundary of this state, a place of business accessible to the public.

(2) The place of business shall be that wherein the licensee principally conducts transactions under his or her license.

(3) The address of the place shall appear upon the license, and the licensee shall promptly notify the Insurance Commissioner in writing of any change of address within ten (10) days of that change of address.

(4) Nothing in this section shall be deemed to prohibit maintenance of the place of business in the licensee’s place of residence in this state.

(b) The licenses of the licensee shall be conspicuously displayed in the place of business in a part thereof customarily open to the public.

(c)(1)(A) The agent or broker shall keep at his or her place of business the usual and customary records pertaining to transactions under his or her license for at least:

(i) Five (5) years from the date the record was created; or

(ii) One (1) year following the final settlement or final adjudication of a criminal proceeding, civil litigation, or an administrative proceeding:

(a) Commenced within five (5) years from the date the record was created; and

(b) Involving records pertaining to a transaction conducted by the agent or broker under his or her license.

(B) A record required to be kept by this subsection may be maintained:

(i) In its original form, electronically, or as a hard copy; and

(ii) By an agent’s or broker’s insurance company on behalf of the agent or broker, relieving the agent or broker’s obligation to maintain the record.

(2) As used in this subsection, “usual and customary records” means:

(A) Applications;

(B) Billing information;

(C) Policy information; and

(D) Claims files.

History. Acts 1959, No. 148, § 172; 1004, § 1; 2009, No. 726, § 29; 2015, No. A.S.A. 1947, § 66-2829; Acts 1997, No. 1223, §§ 27, 28.

23-64-223. Fiduciary duties of licensees.**CASE NOTES****Violations.**

There was substantial evidence to support the revocation of the license of a title insurance company owner because there was a longtime pattern of poor record-keeping, poor management, and questionable business practices that enabled the owner's employee to commit fraud; and the owner disregarded the sanctity of es-

crow accounts and failed to place correct information on title policies regarding his license, business name, and the required statutory notices. Moreover, the sanction was not too harsh because revocation was an available sanction for the violations that occurred. *Dyer v. Ark. Ins. Dep't*, 2015 Ark. App. 446, 468 S.W.3d 303 (2015).

23-64-233. Limited license for self-service storage insurance — Definitions.

(a) As used in this section:

(1) "Customer" means an individual or entity that obtains the use of a storage space from a self-service storage facility under the terms of a self-service storage rental agreement;

(2) "Insured customer" means a customer that purchases insurance under a self-service storage insurance policy that is sold, solicited, or negotiated by a self-service storage facility;

(3) "Limited licensee" means an owner authorized by this section to sell certain coverages relating to the rental of space within a self-service storage facility;

(4)(A) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility.

(B) "Owner" includes an owner's agent and any other person authorized by the owner to manage the self-service storage facility or to receive rent from a customer under a rental agreement;

(5) "Personal property" means movable property not affixed to land and includes without limitation goods, wares, merchandise, household items, and vehicles;

(6) "Rental agreement" means a written agreement or lease that establishes or modifies the terms, conditions, rules, or other provisions concerning the use and occupancy of a self-service storage facility;

(7)(A) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing storage space to customers that are given access to the storage space to store and remove personal property.

(B) "Self-service storage facility" does not include storage space that is used for residential purposes;

(8)(A) "Self-service storage insurance" means insurance that provides coverage for personal property stored at a self-service storage facility during the term of an insured customer's rental agreement against any one (1) or more of the following causes:

- (i) Loss;
- (ii) Theft;

(iii) Damage; or

(iv) Other loss directly related to the rental of the self-service storage space.

(B) "Self-service storage insurance" does not include:

(i) Homeowners or renters insurance; or

(ii) Private passenger automobile, commercial multi-peril, or similar insurance; and

(9) "Supervising entity" means a business entity that is an insurer or insurance producer licensed under the insurance laws of this state.

(b) The Insurance Commissioner may issue to a self-service storage facility that has complied with the requirements of this section a limited license authorizing the limited licensee to offer or sell insurance in connection with the rental of self-service storage facilities and the corresponding rental agreements.

(c) A self-service storage facility shall not sell or offer insurance in connection with the rental of storage space unless the owner has procured a limited license from the commissioner.

(d) The commissioner may issue a limited license to an owner upon written application by the owner, without examination, on a form prescribed by the commissioner.

(e) If this section is violated by a limited licensee or by the limited licensee's employee or authorized representative, the commissioner after notice and a hearing may impose:

(1) A fine not to exceed five hundred dollars (\$500) for each violation or five thousand dollars (\$5,000) in the aggregate; and

(2) Other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this section, including without limitation:

(A) Suspending the privilege of transacting self-service storage insurance under this section at a specific self-service storage facility where a violation has occurred; and

(B) Suspending or revoking the ability of an individual employee or authorized representative of the owner to act under the owner's limited license.

(f) A limited licensee is authorized to offer or sell coverage under a policy of self-service storage insurance on behalf of a licensed insurer only:

(1) In connection with a rental agreement;

(2) As an individual policy issued to an individual customer for personal property insurance;

(3) For policy forms and rates that have been filed in compliance with § 23-67-201 et seq. and § 23-79-101 et seq.; and

(4)(A) When brochures or other written materials have been filed with the commissioner in compliance with § 23-79-101 et seq. and are made readily available to each prospective customer.

(B) The brochures or other written materials shall:

(i) Disclose that self-service storage insurance may duplicate coverage already provided under a customer's homeowners insurance policy, renters insurance policy, or other coverage;

(ii) State that the purchase by the customer of self-service storage insurance is not required in order to lease self-service storage space;

(iii) Clearly and correctly summarize the material terms of each self-service storage insurance policy offered to customers, including without limitation:

(a) The identity of the insurer;

(b) The identity of the supervising entity;

(c) The amount of any applicable deductible and how it is to be paid;

(d) The benefits of the coverage; and

(e) The key terms and conditions of coverage, including without limitation whether covered property may be repaired or replaced;

(iv) Summarize the process for filing a claim;

(v) State that the insured customer may cancel coverage under the self-service storage insurance policy at any time, and the person paying the premium will receive a refund of any unearned premium;

(vi) Disclose that a limited licensee or the employee of the limited licensee may not evaluate or provide advice concerning a prospective occupant's existing insurance coverage; and

(vii) State that the self-service storage facility limited licensee or the employee of the limited licensee is not and may not claim to be a licensed nonlimited lines insurance producer or an insurance expert.

(g) Evidence of self-service storage insurance coverage and its terms and conditions shall be disclosed within the rental agreement and provided to every customer who elects to purchase self-service storage insurance coverage.

(h) A limited license authorizes an employee or an authorized representative of the limited licensee to act individually on behalf of and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subchapter if the employee or authorized representative of the employee does not:

(1) Evaluate or provide advice concerning a prospective customer's existing insurance coverage;

(2) Claim to be a licensed nonlimited lines insurance producer or an insurance expert; or

(3)(A) Obtain compensation based primarily on the numbers of customers enrolled for self-service storage insurance coverage.

(B) However, the employee or authorized representative of the employee may receive compensation for activities under the limited lines license which is incidental to overall compensation.

(i)(1) A limited licensee shall conduct a training program for each employee and authorized representative of an employee that offer self-service storage insurance.

(2) The training program shall include basic instruction about the kinds of coverage specified in this section and offered for purchase by prospective customers of self-service storage facilities.

(j)(1) Charges for self-service storage insurance may be billed and collected by the self-service storage facility.

(2) If the insurance cost is not included in the fees associated with the self-service storage rental agreement, the insurance cost shall be separately itemized on the insured customer's bill.

(3) If the insurance cost is included in the fee associated with a self-service storage rental agreement, the self-service storage facility shall clearly and conspicuously disclose within the rental agreement the price of the self-service storage insurance coverage.

(4) A self-service storage facility that bills and collects the charges for self-service storage insurance shall not be required to maintain the funds in a segregated account if the owner:

(A) Is authorized by the insurer to hold the funds in an alternative manner; and

(B) Remits the funds to the supervising entity within sixty (60) days of receipt of the funds.

(5) Funds received from an insured customer for the sale of self-service storage insurance shall be held in trust by the owner in a fiduciary capacity for the benefit of the insurer.

(6) Owners may receive compensation from the insurer for billing and collecting self-service storage insurance.

History. Acts 2013, No. 588, § 1.

23-64-234. Travel insurance — Scope — Definitions — Licensing — Premium tax.

(a)(1) This section applies to travel insurance that:

(A) Covers a resident of this state;

(B) Is sold, solicited, negotiated, or offered in this state; and

(C) Has policies and certificates that are delivered or issued for delivery in this state.

(2) This section does not apply to a cancellation fee waiver or travel assistance services except as provided in this section.

(3) All other applicable provisions of this state's insurance laws shall continue to apply to travel insurance except that this section shall supersede any general provisions of law that would otherwise be applicable to travel insurance.

(b) As used in this section:

(1)(A) "Aggregator site" means a website that provides access to information regarding insurance products from more than one (1) insurer.

(B) "Aggregator site" includes a website that provides product and insurer information for use in comparison shopping;

(2) "Blanket travel insurance" means a policy issued to an eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group;

(3)(A) "Cancellation fee waiver" means a contractual agreement between a supplier of services for travel and its customer to waive some or all of the nonrefundable cancellation fee provisions of the

underlying travel contract of the supplier with or without regard to the reason for the cancellation or form of reimbursement.

(B) "Cancellation fee waiver" is not insurance under this section;

(4) "Eligible group" means two (2) or more persons who are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, including without limitation any of the following:

(A)(i) An entity engaged in the business of providing travel or services for travel, if in regard to any particular travel or type of travel or travelers, all members or customers of the group have a common exposure to risk attendant to the travel.

(ii) An entity as described in subdivision (b)(4)(A)(i) of this section includes without limitation:

- (a) A tour operator;
- (b) A lodging provider;
- (c) A vacation property owner;
- (d) A hotel or resort;
- (e) A travel club;
- (f) A travel agency;
- (g) A property manager;
- (h) A cultural exchange program; or

(i) A common carrier or the operator, owner, or lessor of a means of transportation of passengers, including without limitation:

- (1) An airline;
- (2) A cruise line;
- (3) A railroad;
- (4) A steamship company; or
- (5) A public bus carrier;

(B) A college, school, or other institution of learning covering students, teachers, employees, or volunteers;

(C) An employer covering a group of employees, volunteers, contractors, members of a board of directors, dependents, or guests;

(D) A sports team, camp, or sponsor thereof covering participants, members, campers, employees, officials, supervisors, or volunteers;

(E) A religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers;

(F) A financial institution or financial institution vendor, parent holding company, trustee, or an agent of a financial institution or financial institution vendor, parent holding company, trustee, or a designee of one (1) or more financial institutions or financial institution vendors, including without limitation an accountholder, credit card holder, debtor, guarantor, or purchaser;

(G) An incorporated or unincorporated association, including without limitation a labor union, that has a common interest, constitution, and bylaws and is organized and maintained in good faith for purposes other than obtaining insurance for members or participants of the association covering its members;

(H) A trust or the trustees of a fund that is established, created, or maintained for the benefit of and covering members, employees, or customers, subject to the permission of the Insurance Commissioner to use a trust and the state's premium tax provisions, as provided in subdivision (d)(1) of this section, of one (1) or more associations meeting the requirements of subdivision (b)(4)(G) of this section;

(I) An entertainment production company covering a group of participants, volunteers, audience members, contestants, or workers;

(J) A volunteer fire department, ambulance, rescue, police, court, or any first aid, civil defense, or other similar volunteer group;

(K) A preschool, daycare institution for children or adults, or senior citizen club;

(L)(i) An automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers as defined by their travel status on the rented or leased vehicles.

(ii) A common carrier, owner, operator, or lessor of a means of transportation, or an automobile or truck rental or leasing company, is the policyholder under a policy to which this section applies; or

(M) Any other group if the commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest;

(5) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and travel assistance services details;

(6) "Group travel insurance" means travel insurance issued to an eligible group;

(7) "Limited lines travel insurance producer" means:

(A) A managing general agent;

(B) An insurance producer, including a limited lines producer; or

(C) A travel administrator;

(8) "Offer and disseminate" means to:

(A) Provide general information, including without limitation a description of the insurance coverage and the cost of the insurance coverage;

(B) Process an application for insurance coverage;

(C) Collect the premiums for insurance coverage; and

(D) Perform other nonlicensed activities allowed by the insurance laws of this state;

(9) "Primary certificate holder" means an individual who elects and purchases travel insurance under a group policy;

(10) "Primary policyholder" means an individual who elects and purchases a policy for individual travel insurance;

(11)(A) "Travel administrator" means a person that, directly or indirectly, underwrites, collects or charges collateral or premiums from, or adjusts or settles claims on, residents of this state in connection with travel insurance.

(B) "Travel administrator" does not include a person whose only actions that would otherwise cause it to be considered a travel administrator are among the following:

(i) The person works for a travel administrator to the extent that the person's activities are subject to the supervision and control of the travel administrator;

(ii) The person is an insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the license of the insurance producer;

(iii) The person is a travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer according to this section;

(iv) The person is an individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney-at-law and does not collect charges or premiums in connection with insurance coverage; or

(v) The person is a business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer;

(12)(A) "Travel assistance service" means a noninsurance service:

(i) For which the consumer is not indemnified based on a fortuitous event; and

(ii) That does not result in the transfer or shifting of risk that would constitute the business of insurance.

(B) "Travel assistance services" includes without limitation:

(i) Security advisories;

(ii) Destination information;

(iii) Vaccination and immunization information services;

(iv) Travel reservation services;

(v) Entertainment;

(vi) Activity and event planning;

(vii) Translation assistance;

(viii) Emergency messaging;

(ix) International legal and medical referrals;

(x) Medical case monitoring;

(xi) Coordination of transportation arrangements;

(xii) Emergency cash transfer assistance;

(xiii) Medical prescription replacement assistance;

(xiv) Passport and travel document replacement assistance;

(xv) Lost luggage assistance;

(xvi) Concierge services; and

(xvii) Any other service that is furnished in connection with planned travel.

(C) "Travel assistance services" is not considered insurance and is not related to insurance;

(13)(A) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including without limitation:

(i) Interruption or cancellation of a trip or event;

- (ii) Loss of baggage or personal effects;
- (iii) Damages to accommodations or rental vehicles;
- (iv) Sickness, accident, disability, or death occurring during travel;
- (v) Emergency evacuation;
- (vi) Repatriation of remains; or
- (vii) Any other contractual obligations to indemnify or pay a specified amount to a traveler upon determinable contingencies related to travel as approved by the commissioner.

(B) "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers on trips lasting longer than six (6) months, including without limitation an individual who is working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license;

(14) "Travel protection plan" means a plan that provides one (1) or more of the following:

- (A) Travel insurance;
- (B) Travel assistance services; or
- (C) Cancellation fee waivers; and

(15) "Travel retailer" means a business entity that makes, arranges, or offers planned travel and offers and disseminates travel insurance as a service to a customer of the business entity on behalf of and under the direction of a limited lines travel insurance producer.

(c)(1)(A) The commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed with the commissioner an application for a limited lines travel insurance producer license in a form and manner prescribed by the commissioner.

(B) A limited lines travel insurance producer shall be licensed to sell, solicit, and negotiate travel insurance through a licensed insurer.

(C) A person shall not act as a limited lines travel insurance producer or travel retailer unless properly licensed or registered under the insurance laws of this state.

(2) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(A) A limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

- (i) Actual material terms of the insurance coverage or a description of the material terms;

- (ii) A description of the process for filing a claim;

- (iii) A description of the review or cancellation process for the travel insurance policy; and

- (iv) The identity of and contact information for the insurer and limited lines travel insurance producer;

(B)(i) A limited lines travel insurance producer establishes at the time of licensure and maintains a register, on a form prescribed by the commissioner, of each travel retailer that offers travel insurance on behalf of the limited lines travel insurance producer in this state.

(ii) A register described under subdivision (c)(2)(B)(i) of this section shall be maintained and updated by the limited lines travel insurance producer and include:

(a) The name, address, and contact information for the travel retailer and an officer or other person who directs or controls the travel retailer's operations; and

(b) The federal employer identification number of the travel retailer.

(iii) The limited lines travel insurance producer shall:

(a) Provide the register described under subdivision (c)(2)(B)(i) of this section on application for and renewal of a limited lines travel insurance producer license; and

(b) Certify that the travel retailer registered is in compliance with 18 U.S.C. § 1033, as it existed on January 1, 2019.

(iv) The grounds for the suspension, revocation, and any penalties that are applicable to resident insurance producers shall be applicable to the limited lines travel insurance producers and travel retailers;

(C) A limited lines travel insurance producer has designated an employee who is a licensed individual producer who shall be known as a designated responsible producer, to be responsible for compliance with the travel insurance laws and regulations applicable to the limited lines travel insurance producer and its registrants;

(D) A designated responsible producer, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

(E) A limited lines travel insurance producer pays the applicable insurance producer licensing fees; and

(F)(i) A limited lines travel insurance producer requires each employee and authorized representative of the travel retailer that offers and disseminates travel insurance to receive instruction or training that may be reviewed and approved by the commissioner.

(ii) At a minimum, the training material shall contain instructions on the types of insurance offered, ethical sales practices, and the required disclosures to provide to customers.

(3)(A) A travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that have been approved by the insurer.

(B) A brochure or other written materials, at a minimum, shall contain the following information:

(i) The identity of and contact information for the insurer and limited lines travel insurance producer;

(ii) An explanation that the purchase of travel insurance is not required to purchase any other product or service from the travel retailer; and

(iii) An explanation that an unlicensed travel retailer may provide general information about the insurance coverage offered by the travel retailer, including a description of the insurance coverage and the cost of the insurance coverage, but shall not answer technical questions about the insurance terms and conditions offered by the travel retailer or provide an evaluation of the adequacy of any existing insurance coverage.

(4) A travel retailer employee or authorized representative of the travel retailer that is not licensed as an insurance producer shall not:

(A) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(B) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(C) Hold themselves or itself out as a licensed insurer, producer, or insurance expert.

(5) Notwithstanding any other provision in law, a travel retailer, its employees, and authorized representatives of the travel retailer that receive training under subdivision (c)(2)(F)(i) of this section and whose insurance-related activities are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer that is licensed under this subchapter may receive compensation if listed on the registry maintained by the limited lines travel insurance producer under subdivision (c)(2)(B)(i) of this section.

(6) As an insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this section.

(7)(A) A person licensed in a major line of authority as an insurance producer is authorized to sell, solicit, and negotiate travel insurance.

(B) A property and casualty insurance producer is not required to become appointed by an insurer in order to sell, solicit, or negotiate travel insurance.

(d)(1) An insurer shall pay premium tax, as provided in § 26-57-603, on travel insurance premiums paid by any of the following:

(A) An individual primary policyholder who is a resident of this state;

(B) A primary certificate holder who is a resident of this state and elects coverage under a group travel insurance policy; or

(C) A blanket travel insurance policyholder that is a resident in, or has its principal place of business or the principal place of business of an affiliate or subsidiary in, this state if that affiliate or subsidiary has purchased blanket travel insurance in this state for eligible blanket group members, and subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permits the insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(2) An insurer shall:

(A) Document the state of residence or principal place of business of the primary policyholder or primary certificate holder, as required in subdivision (d)(1) of this section; and

(B) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

(e) A travel protection plan may be offered for one (1) price for the combined features that the travel protection plan offers in this state if:

(1) A travel protection plan clearly discloses to the consumer at or before the time of purchase that the travel protection plan includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity at or before the time of purchase for the consumer to obtain additional information regarding the features and pricing of each; and

(2) The fulfillment materials:

(A) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(B) Include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

(f)(1)(A) Except as provided in subdivision (f)(1)(B) of this section, a person offering travel insurance to residents of this state is subject to the Trade Practices Act, § 23-66-201 et seq.

(B) If a conflict exists between this section and any other insurance law of this state regarding the sale and marketing of travel insurance and travel protection plans, this section controls.

(2) Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under the Trade Practices Act, § 23-66-201 et seq.

(3)(A) All documents provided to consumers before the purchase of travel insurance, including without limitation sales materials and marketing materials, shall be consistent with the travel insurance policy itself, including without limitation, forms, endorsements, policies, rate filings, and certificates of insurance.

(B) For travel insurance policies or certificates that contain pre-existing condition exclusions, information and an opportunity to learn more about the pre-existing condition exclusions shall be provided any time before the time of purchase and in the coverage's fulfillment materials.

(C)(i) The fulfillment materials and the information described in subdivision (c)(2)(A) of this section shall be provided to a primary policyholder or primary certificate holder as soon as practicable following the purchase of a travel protection plan.

(ii)(a) Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a primary policyholder or primary certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

(1) Fifteen (15) days after the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

(2) Ten (10) days after the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

(b) For purposes of subdivision (f)(3)(C)(ii)(a) of this section, "delivery" means handing fulfillment materials to the primary policyholder or primary certificate holder or sending fulfillment materials by postal mail or electronic means to the primary policyholder or primary certificate holder.

(D) The policy documentation and fulfillment materials shall disclose whether the travel insurance is primary or secondary to other applicable coverage.

(E) If travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it shall not be an unfair trade practice or other violation of law when an accurate summary or short description of coverage is provided on the insurer's website or aggregator site, so long as the consumer has access to the full provisions of the policy through electronic means.

(4) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis shall not do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when the consumer purchases a trip.

(5) It is an unfair trade practice under the Trade Practices Act, § 23-66-201 et seq., to market blanket travel insurance coverage as free.

(6) If a consumer's destination jurisdiction requires insurance coverage, it is not an unfair trade practice under the Trade Practices Act, § 23-66-201 et seq., to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(A) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(B) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements before departure.

(g)(1) Notwithstanding any other provision of insurance laws in this state, a person shall not act or represent itself as a travel administrator for travel insurance in this state unless that person:

(A) Is a licensed property and casualty insurance producer in this state for activities permitted under that property and casualty insurance producer license; or

(B) Holds a valid managing general agent license in this state.

(2) A travel administrator and its employees are exempt from the licensing requirements for adjusters under § 23-64-201 for travel insurance it administers.

(3) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer and is responsible for ensuring that the travel administrator maintains all

books and records relevant to the insurer to be made available by the travel administrator to the commissioner upon request.

(h)(1) Notwithstanding any other provision of the insurance laws of this state, travel insurance shall be classified and filed for purposes of rates and forms as marine insurance, provided, however, that travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains or in conjunction with incidental limited property and casualty benefits such as baggage or trip cancellation, may be filed by an authorized insurer under either an accident and health line of insurance or a marine line of insurance.

(2) Travel insurance may be in the form of an individual, group, or blanket policy.

(3) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided those standards also meet the state's underwriting standards for marine insurance.

(i)(1) The commissioner shall promulgate rules necessary to implement this section.

(2)(A) When adopting the initial rules to implement this section, the final rule shall be filed with the Secretary of State for adoption under § 25-15-204(f):

(i) On or before January 1, 2020; or

(ii) If approval under § 10-3-309 has not occurred by January 1, 2020, as soon as practicable after approval under § 10-3-309.

(B) The commissioner shall file the proposed rule with the Legislative Council under § 10-3-309(c) sufficiently in advance of January 1, 2020, so that the Legislative Council may consider the rule for approval before January 1, 2020.

History. Acts 2019, No. 698, § 3.

Effective Dates. Acts 2019, No. 698,

§ 4: "This act is effective for travel insurance sold on or after October 1, 2019."

SUBCHAPTER 3 — CONTINUING EDUCATION

SECTION.

23-64-301. Continuing education required.

SECTION.

23-64-302. Requirements for licensees — Exceptions.

23-64-301. Continuing education required.

(a)(1) Unless exempt under § 23-64-302, an insurance producer licensed in this state shall successfully complete and report the courses of instruction required by this section within the biennial period prescribed by rule of the Insurance Commissioner for the insurance producer to satisfy the continuing education requirements necessary to continue the insurance producer's license.

(2) The exemptions in § 23-64-302(3) and (4) do not apply to an insurance producer licensed after July 1, 2003.

(3) A resident insurance producer who qualified for an exemption under § 23-64-302(3) or (4) and then moved to another state may maintain the exemption when the insurance producer returns to this state if upon application to the commissioner for a reinstatement of the exemption the insurance producer has been continuously licensed in this state as a resident or nonresident insurance producer from the time he or she first qualified for the exemption.

(b) An individual who holds a title insurance license shall complete the minimum number of hours of continuing education courses established by rule of the commissioner.

(c) The commissioner may promulgate rules containing the continuing education requirements for insurance producers licensed in this state as necessary for continued uniformity among the states.

(d) The commissioner may hire an independent contractor to administer all or part of this subchapter in a fair and impartial manner.

History. Acts 1989, No. 445, § 1; 1997, No. 726, § 31; 2011, No. 760, § 7; 2013, No. 1004, § 1; 2001, No. 1603, § 20; 2003, No. 534, § 1.
No. 1784, § 1; 2007, No. 684, § 4; 2009,

23-64-302. Requirements for licensees — Exceptions.

The provisions of this subchapter shall not apply to:

(1) Those natural persons holding licenses for any kind or kinds of insurance for which an examination is not required by the laws of this state;

(2) Any limited or restricted license the Insurance Commissioner may exempt;

(3) Any natural person who is at least sixty (60) years of age;

(4) Any natural person who has held an active license as an agent, solicitor, consultant, or broker for a period of at least fifteen (15) consecutive years;

(5) The licensee as a firm, limited liability company, or corporation, but this exception does not apply to any individual or natural person unless already exempted;

(6) Nonresident producers;

(7) Licensed insurance consultants for life, accident and health, property, or casualty insurance or for other lines of insurance;

(8) Nonresident agents and brokers in the first full year of resident licensing following the year after a change in the state of domicile or residency to the State of Arkansas, but thereafter annually or otherwise in accordance with insurance continuing education laws and rules of the commissioner; and

(9) A member of the Arkansas National Guard on state active duty or a member of the United States Armed Forces on active duty, including without limitation an active duty member of the:

(A) United States Coast Guard; or

(B) United States reserves.

History. Acts 1989, No. 445, § 1; 1993, No. 901, § 30; 1997, No. 1004, § 1; 1999, No. 657, § 8; 2001, No. 1603, § 21; 2003, No. 1784, § 2; 2005, No. 1697, § 5; 2019, No. 315, § 2651; 2019, No. 462, § 18.

Amendments. The 2019 amendment by No. 315 deleted “and regulations” following “rules” in (8).

The 2019 amendment by No. 462 rewrote (9).

SUBCHAPTER 4 — MANAGING GENERAL AGENTS ACT

SECTION.

23-64-404. Agency contracts — Provisions.

SECTION.

23-64-408. Insurance Commissioner's authority to adopt rules.

23-64-404. Agency contracts — Provisions.

No person, firm, association, limited liability company, or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, when both parties share responsibility for a particular function, specifies the division of the responsibilities, and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;

(3) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three (3) months' estimated claims payments and allocated loss adjustment expenses;

(4) Separate records of business written by the managing general agent will be maintained. The insurer shall have access and the right to copy all accounts and records related to its business in a form usable by the insurer, and the Insurance Commissioner shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner;

(5) The contract may not be assigned in whole or part by the managing general agent;

(6)(A) Appropriate underwriting guidelines, including:

- (i) The maximum annual premium volume;
- (ii) The basis of the rates to be charged;
- (iii) The types of risks which may be written;
- (iv) Maximum limits of liability;
- (v) Applicable exclusions;
- (vi) Territorial limitations;
- (vii) Policy cancellation provisions; and

(viii) The maximum policy period.

(B) The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and rules of this state concerning the cancellation and nonrenewal of insurance policies;

(7) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(A) All claims must be reported to the company in a timely manner;

(B) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six (6) months; or

(v) Is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less;

(C) All claim files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files shall become the sole property of the insurer or its estate. The managing general agent shall have reasonable access to and the right to copy the files on a timely basis; and

(D) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination;

(8) When electronic claims files are in existence, the contract must address the timely transmission of the data;

(9) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until one (1) year after they are earned for property insurance business and five (5) years after they are earned on casualty business and not until the profits have been verified pursuant to § 23-64-405; and

(10) The managing general agent shall not:

(A) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(B) Commit the insurer to participate in insurance or reinsurance syndicates;

(C) Appoint any agent without assuring that the agent is lawfully licensed to transact the type of insurance for which appointed;

(D) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(E) Collect any payment from a reinsurer, or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(F) Permit its subagent to serve on the insurer's board of directors;

(G) Jointly employ an individual who is employed with the insurer;

or

(H) Appoint a managing general subagent.

History. Acts 1993, No. 1094, § 1; 1997, No. 1004, § 1; 2019, No. 315, § 2652. **Amendments.** The 2019 amendment substituted "rules" for "regulations" in (6)(B).

23-64-408. Insurance Commissioner's authority to adopt rules.

The Insurance Commissioner may adopt reasonable rules for the implementation and administration of the provisions of this subchapter.

History. Acts 1993, No. 1094, § 1; 1997, No. 1004, § 1; 2019, No. 315, § 2653. substituted "authority to adopt rules" for "regulatory authority" in the section heading; and deleted "and regulations" following

Amendments. The 2019 amendment substituted "rules" in the text.

SUBCHAPTER 5 — PRODUCER LICENSING MODEL ACT

SECTION.

23-64-505. Application for examination.
23-64-506. Application for license.
23-64-507. License.
23-64-509. Exemption from examination.

SECTION.

23-64-511. Temporary licensing.
23-64-514. Appointments.
23-64-518. Rules.

23-64-505. Application for examination.

(a) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to § 23-64-205. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws of this state. Examinations required by this section shall be developed and conducted under rules prescribed by the Insurance Commissioner.

(b) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and

collecting the nonrefundable fee set forth in § 23-61-401 and any existing or future rule and regulation.

(c) Each individual applying for an examination shall remit a non-refundable fee as prescribed by the commissioner as set forth in § 23-61-401 and any existing or future rule and regulation.

(d) An individual who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

History. Acts 2001, No. 580, § 1; 2019, No. 315, § 2654.

Amendments. The 2019 amendment, in (a), deleted “and regulations” following

“laws” in the second sentence and deleted “and regulations” following “rules” in the third sentence.

23-64-506. Application for license.

(a) A person applying for a resident insurance producer license shall make application to the Insurance Commissioner on the National Association of Insurance Commissioners’ Uniform Application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual’s knowledge and belief. Before approving the application, the commissioner shall find that the individual:

- (1) Is at least eighteen (18) years of age;
- (2) Has not committed any act that is a ground for denial, suspension, or revocation set forth in § 23-64-512;
- (3) When required by the commissioner, has completed a prelicensing course of study for the lines of authority for which the person has applied;
- (4) Has paid the fees set forth in § 23-61-401 and any existing or future rule and regulation; and
- (5) Has successfully passed the examinations for the lines of authority for which the person has applied.

(b) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the Uniform Business Entity Application. Before approving the application, the commissioner shall find that:

- (1) The business entity has paid the fees set forth in § 23-61-401 and any existing or future rule and regulation; and
- (2) The business entity has designated a licensed producer responsible for the business entity’s compliance with the insurance laws and rules of this state.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in an application and shall cause to be conducted an investigation of the applicant’s:

- (1) Background;
- (2) Trustworthiness;
- (3) Personal and business reputation; and

(4) Financial responsibility.

(d) Each insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited line credit insurance a program of instruction that may be approved by the commissioner.

(e)(1) To obtain or renew an insurance producer's license, a resident applicant or producer must be deemed by the commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation.

(2) Qualifications for licensure under this section must continue in order to remain licensed.

(3) On a case-by-case basis, the commissioner may require documentation to verify qualification for licensure under this section.

History. Acts 2001, No. 580, § 1; 2003, No. 1203, § 10; 2005, No. 1697, § 6; 2019, No. 315, § 2655.

Amendments. The 2019 amendment substituted "and rules" for "rules and regulations" in (b)(2).

23-64-507. License.

(a) Unless denied licensure pursuant to § 23-64-512, persons who have met the requirements of §§ 23-64-505 and 23-64-506 shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:

(1) Life insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(2) Accident and health or sickness insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income;

(3) Property insurance coverage for the direct or consequential loss or damage to property of every kind;

(4) Casualty insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property;

(5) Variable life and variable annuity products insurance coverage provided under variable life insurance contracts and variable annuities;

(6) Personal lines property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(7) Credit limited line credit insurance; or

(8) Any other line of insurance permitted under state laws or regulations.

(b) An insurance producer license shall remain in effect unless revoked or suspended:

(1) As long as the fee set forth in § 23-61-401 and any existing or future rule is paid and education requirements for resident individual producers are met by the due date; or

(2)(A) During any period of state active duty in the Arkansas National Guard or active duty in any branch of the United States

military services or as a member of the Arkansas National Guard on active duty, including without limitation the:

- (i) United States Coast Guard; or
- (ii) United States reserves.

(B) The requirements of subdivision (b)(1) of this section are waived during the period of active duty.

(c) An individual insurance producer who allows his or her license to lapse may reinstate the same license within twelve (12) months after the due date of the renewal fee without the necessity of passing a written examination. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.

(d) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, for example, a long-term medical disability, may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(e) The license shall contain the licensee's name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date, and any other information the Insurance Commissioner deems necessary.

(f) Licensees shall inform the commissioner by any means acceptable to the commissioner of a change of address within thirty (30) days of the change. Failure to timely inform the commissioner of a change in legal name or address shall result in a penalty pursuant to § 23-64-216.

(g) In order to assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the commissioner and the nongovernmental entity may deem appropriate.

History. Acts 2001, No. 580, § 1; 2005, by No. 315 deleted "and regulation" following "rule" in (b)(1).
No. 1697, § 7; 2019, No. 315, § 2656; 2019, No. 462, § 19.

The 2019 amendment by No. 462 re-wrote (b)(2).

Amendments. The 2019 amendment

23-64-509. Exemption from examination.

(a) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety (90) days after the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the

state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates, or its subsidiaries, and indicates that the producer is or was licensed in good standing for the line of authority requested.

(b) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days after establishing legal residence to become a resident licensee pursuant to § 23-64-506. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except when the Insurance Commissioner determines otherwise by rule.

History. Acts 2001, No. 580, § 1; 2019, No. 315, § 2657.

substituted "rule" for "regulation" at the end of the last sentence of (b).

Amendments. The 2019 amendment

23-64-510. Assumed names.

CASE NOTES

Violation.

There was substantial evidence to support the revocation of the license of a title insurance company owner because there was a longtime pattern of poor record-keeping, poor management, and questionable business practices that enabled the owner's employee to commit fraud; and the owner disregarded the sanctity of es-

crow accounts and failed to place correct information on title policies regarding his license, business name, and the required statutory notices. Moreover, the sanction was not too harsh because revocation was an available sanction for the violations that occurred. *Dyer v. Ark. Ins. Dep't*, 2015 Ark. App. 446, 468 S.W.3d 303 (2015).

23-64-511. Temporary licensing.

(a) The Insurance Commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty (180) days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(3) To the designee of a licensed insurance producer entering active duty in the United States Armed Forces or state active duty in the Arkansas National Guard; or

(4) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this license.

(b) The commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

History. Acts 2001, No. 580, § 1; 2019, No. 462, § 20.

Amendments. The 2019 amendment substituted “duty in the United States

Armed Forces or state active duty in the Arkansas National Guard” for “service in the armed forces of the United States” in (a)(3).

23-64-512. License denial, nonrenewal, or revocation.

CASE NOTES

Revocation Proper.

There was substantial evidence to support the revocation of the license of a title insurance company owner because there was a longtime pattern of poor record-keeping, poor management, and questionable business practices that enabled the owner’s employee to commit fraud; and the owner disregarded the sanctity of es-

crow accounts and failed to place correct information on title policies regarding his license, business name, and the required statutory notices. Moreover, the sanction was not too harsh because revocation was an available sanction for the violations that occurred. *Dyer v. Ark. Ins. Dep’t*, 2015 Ark. App. 446, 468 S.W.3d 303 (2015).

23-64-514. Appointments.

(a) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(b) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the Insurance Commissioner, a notice of appointment within fifteen (15) days after the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer’s holding company system or group by the filing of a single appointment request.

(c) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time not to exceed thirty (30) days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the insurer within five (5) days after the commissioner’s determination.

(d) An insurer shall pay an appointment fee, in the amount and method of payment set forth in § 23-61-401 and any existing or future rule, for each insurance producer appointed by the insurer.

(e) An insurer shall remit, in a manner prescribed by the commissioner, a renewal appointment fee in the amount set forth in § 23-61-401 and any existing or future rule.

History. Acts 2001, No. 580, § 1; 2019, No. 315, § 2658. deleted “and regulation” following “rule” in (d) and (e).

Amendments. The 2019 amendment

23-64-518. Rules.

The Insurance Commissioner may, in accordance with § 23-61-108, promulgate reasonable rules as are necessary or proper to carry out the purposes of this subchapter.

History. Acts 2001, No. 580, § 1; 2019, No. 315, § 2659. substituted “rules” for “regulations” in the section heading and in the text.

Amendments. The 2019 amendment

SUBCHAPTER 6 — ARKANSAS HEALTH INSURANCE MARKETPLACE NAVIGATOR, GUIDE, AND CERTIFIED APPLICATION COUNSELORS ACT

SECTION.

- 23-64-601. Title.
- 23-64-602. Definitions.
- 23-64-603. Navigator license required.
- 23-64-604. Guide license required.
- 23-64-605. Certified application counselor license required.
- 23-64-606. Licensed producer — Certification required.
- 23-64-607. Qualifications for licensure or certification — Issuance.

SECTION.

- 23-64-608. License renewal.
- 23-64-609. Additional licensee duties.
- 23-64-610. Prohibited activities.
- 23-64-611. Disciplinary authority.
- 23-64-612. Authority — Grants and contracts.
- 23-64-613. Rules.
- 23-64-614. Relation to other laws.

A.C.R.C. Notes. A health insurance marketplace has been initiated and operating in Arkansas since 2013-2014 pursuant to Acts 2013, No. 1500.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: “This act is effective when:

“(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued

under those federal statutes; or

“(2) A health insurance marketplace is initiated and is operable in this state.”

Acts 2019, No. 910, § 6346(b): July 1, 2019. Emergency clause provided: “It is found and determined by the General Assembly of the State of Arkansas that this act revises the duties of certain state entities; that this act establishes new departments of the state; that these revisions impact the expenses and operations of state government; and that the sections of this act other than the two uncodified sections of this act preceding the emergency clause titled ‘Funding and classification of cabinet-level department secretaries’ and ‘Transformation and

Efficiencies Act transition team' should become effective at the beginning of the fiscal year to allow for implementation of the new provisions at the beginning of the fiscal year. Therefore, an emergency is

declared to exist, and Sections 1 through 6343 of this act being necessary for the preservation of the public peace, health, and safety shall become effective on July 1, 2019."

23-64-601. Title.

This subchapter shall be known and may be cited as the "Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act".

History. Acts 2013, No. 1439, § 1.

23-64-602. Definitions.

As used in this subchapter:

(1) "Applicant" means a person who has applied to become licensed under this subchapter as a navigator, guide, certified application counselor, or certified licensed producer;

(2) "Certified application counselor" means a person who is licensed under this subchapter to assist in enrolling consumers in a variety of marketplace-designated organizations settings, including without limitation a healthcare facility, but is not compensated by federal marketplace funds;

(3) "Certified licensed producer" means a person who is:

(A) Licensed as an insurance producer as defined in § 23-64-502;

(B) Certified under this subchapter to:

(i) Educate consumers about health insurance marketplaces, Medicaid, tax credits, and other cost-sharing reductions; and

(ii) Assist consumers with enrollment in a health insurance marketplace;

(C) Eligible to receive commissions from health insurers; and

(D) Not compensated under the federal act, federal regulations, or any guidance issued under the federal act or federal regulations;

(4) "Consumer" means an individual, family, or small business located in this state;

(5) "Enrollment" means enrolling in a qualified health plan offered through a health insurance marketplace;

(6) "Federal act" means the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to or regulations or guidance issued under those statutes existing on the effective date of this act;

(7) "Guide" means a person who is licensed under this subchapter to provide in-person assistance and services as stated in 45 C.F.R. § 155.210;

(8)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver,

arrange for, pay for, or reimburse any of the costs of healthcare services.

(B) "Health benefit plan" does not include:

- (i) Coverage only for accident or disability income insurance, or both;
- (ii) Coverage issued as a supplement to liability insurance;
- (iii) Liability insurance, including without limitation general liability insurance and automobile liability insurance;
- (iv) Workers' compensation or similar insurance;
- (v) Automobile medical payment insurance;
- (vi) Credit-only insurance;
- (vii) Coverage for on-site medical clinics; or
- (viii) Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act, under which benefits for healthcare services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

- (i) Limited scope dental or vision benefits;
- (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or a combination of these; or
- (iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act.

(D) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

- (i) Coverage only for a specified disease or illness; or
- (ii) Hospital indemnity or other fixed indemnity insurance.

(E) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

- (i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, Pub. L. No. 74-271, as existing on the effective date of this act;
- (ii) Coverage supplemental to the coverage provided to military personnel and their dependents under Chapter 55 of Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services, 32 C.F.R. Part 199; or
- (iii) Similar supplemental coverage provided to coverage under a group health plan;

(9) "Health insurance" means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining health insurance, but excluding:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Coverage only for limited scope vision benefits;

(I) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(J) Coverage for specified disease or critical illness;

(K) Hospital indemnity or other fixed indemnity insurance;

(L) Medicare supplement policies;

(M) Medicare, Medicaid, or the Federal Employees Health Benefits Program, 5 U.S.C. §§ 8901 — 8914, as it existed on January 1, 2013;

(N) Coverage only for medical and surgical outpatient benefits;

(O) Excess or stop-loss insurance; and

(P) Other similar insurance coverage:

(i) Under which benefits for health insurance are secondary or incidental to other insurance benefits; or

(ii) Specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act, under which benefits for healthcare services are secondary or incidental to other insurance benefits;

(10) "Health insurance marketplace" means the vehicle created to help consumers in this state shop for and select health insurance coverage in a way that permits comparison of available qualified health plans based on price, benefits, services, and quality, regardless of its governance structure;

(11) "Health insurer" means an entity that provides health insurance or a health benefit plan in this state, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits in this state, and is subject to state insurance regulation;

(12) "License" means a document issued by the Insurance Commissioner authorizing a person to act as a navigator, guide, certified application counselor, or certified licensed producer;

(13) "Licensee" means a navigator, guide, certified application counselor, or certified licensed producer who is licensed under this subchapter;

(14) "Navigator" means a person authorized under the federal act to assist consumers to shop for and select health insurance offered through a health insurance marketplace, including providing information to a consumer on a health benefit plan or coverage offered through a health insurance marketplace, or facilitates enrollment in a health insurance marketplace;

(15) "Non-navigator assistance personnel" means a person authorized under the federal act to assist consumers to enroll and understand the health insurance offered through a health insurance marketplace;

(16) "Person" means an individual, company, firm, organization, association, corporation, government entity, nongovernmental entity, or any other type of legal entity; and

(17) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act.

History. Acts 2013, No. 1439, § 1.

23-64-603. Navigator license required.

(a)(1) A person shall not act as a navigator in this state through a health insurance marketplace unless licensed under this subchapter as an eligible entity.

(2) A health insurer or an affiliate of a health insurer is not an eligible entity.

(b) A grant awarded under a navigator contract is contingent on a person's:

(1) Being licensed under this subchapter;

(2) Becoming licensed under this subchapter by September 30, 2013, or within ninety (90) days after the receipt of funding; or

(3) Employing a licensee that meets the requirements in subdivision (b)(1) or subdivision (b)(2) of this section.

(c) A navigator shall:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 as existing on the effective date of this act and cost-sharing reductions under section 1402 of the federal act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or to any other appropriate state agency or agencies for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage; and

(5) Provide enrollment information in a culturally and linguistically appropriate manner that meets the needs of the population being served by a health insurance marketplace in this state, including those individuals with limited English proficiency or who are protected under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165, as they existed on January 1, 2013.

(d) A navigator shall not advise a person to select a particular plan.

History. Acts 2013, No. 1439, § 1.

Revenue Code of 1986, referred to in this

U.S. Code. Section 36B of the Internal Revenue Code, is codified as 26 U.S.C. § 36B.

23-64-604. Guide license required.

(a)(1) A person shall not act as a guide in this state through a health insurance marketplace unless licensed under this subchapter as an eligible entity.

(2) A health insurer or an affiliate of a health insurer is not an eligible entity.

(b) A contract awarded to a guide is contingent on a person's:

(1) Being licensed under this subchapter;

(2) Becoming licensed under this subchapter by September 30, 2013, or within ninety (90) days after the receipt of funding; or

(3) Employing a licensee that meets the requirements in subdivision (b)(1) or subdivision (b)(2) of this section.

(c) A guide shall:

(1) Assist consumers in understanding the available qualified health plans offered through a health insurance marketplace, their differences, premium tax credits, cost-sharing provisions, and the public programs and their eligibility;

(2) Provide enrollment information in a culturally and linguistically appropriate manner that meets the needs of the population being served by a health insurance marketplace in this state, including those individuals with limited English proficiency or who are protected under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165, as they existed on January 1, 2013;

(3) Ensure that information is provided in a way that simplifies choices and considers the individual needs of consumers;

(4) Maintain expertise in eligibility, enrollment, and public and private insurance specifications and conduct public education activities to raise awareness about the health insurance marketplace in this state;

(5) Provide information and services in a fair, accurate, and impartial manner that acknowledges other health programs;

(6) Increase awareness of insurance options in a way that does not stigmatize qualified health plans;

(7) Facilitate enrollment in qualified health plans or coverage offered through a health insurance marketplace and with post-enrollment dispute resolution;

(8) Provide referrals to an applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, 42 U.S.C. § 300gg et seq., as it existed on January 1, 2013, or any other appropriate state agency or agencies, for a consumer participating in enrollment with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under the plan or coverage;

(9) Not receive any financial consideration directly or indirectly from a health insurer or stop-loss insurance company or qualified health plan;

(10) Demonstrate that no conflict of interest exists in providing in-person assistance and the services as stated in 45 C.F.R. § 155.210; and

(11) Provide resources or avenues for consumers to register complaints and grievances with a service provided through the health insurance marketplace.

History. Acts 2013, No. 1439, § 1.

23-64-605. Certified application counselor license required.

(a)(1) A person shall not act as a certified application counselor in this state through a health insurance marketplace unless licensed under this subchapter and working for a marketplace-designated organization.

(2) A health insurer or an affiliate of a health insurer is not an eligible entity.

(b) A certified application counselor shall assist in enrolling a consumer in a qualified health plan through a health insurance marketplace.

History. Acts 2013, No. 1439, § 1.

23-64-606. Licensed producer — Certification required.

A person shall not act as a certified licensed producer in this state through a health insurance marketplace unless certified under this subchapter.

History. Acts 2013, No. 1439, § 1.

23-64-607. Qualifications for licensure or certification — Issuance.

(a) To qualify for a license or certification under this subchapter, a person shall:

(1) Be at least eighteen (18) years of age;

(2) Have received a high school diploma or a high school equivalency diploma approved by the Adult Education Section of the Division of Workforce Services;

(3) Be competent, trustworthy, financially responsible, and of good personal and business reputation;

(4) Continue the qualifications under subdivision (a)(3) of this section while licensed or certified;

(5)(A) Pass an examination and satisfy the educational requirements the Insurance Commissioner may impose by rule or order.

(B) The examination required by this section shall be developed and conducted under rules prescribed by the commissioner;

(6)(A) Have received instruction in health insurance, the provisions of the federal act for a health insurance marketplace in this state, and the medical assistance programs of this state.

(B) The instruction required by this section shall be developed and conducted under rules prescribed by the commissioner; and

(7) For a certified licensed producer, be a licensee in good standing under the Producer Licensing Model Act, § 23-64-501 et seq.

(b) In addition to the other information required under this subchapter or rules adopted by the commissioner, an application for a license or certification under this subchapter shall include:

(1) The applicant's business name, address, and Social Security number or taxpayer identification number;

(2) A criminal and regulatory background check of the applicant; and

(3) A description of the applicant's current business operations and its activities, duties, and responsibilities, including without limitation:

(A) The place of organization and a certified copy of the applicant's organizational and governance documents;

(B) If a foreign business, a copy of the certificate of authority from the Secretary of State;

(C) The proposed method of business operation and, if applicable, other locations for doing business; and

(D)(i) The qualifications, business experience and history, and financial condition of the applicant, its affiliates, and its employees.

(ii) Information required under subdivision (b)(3)(D)(i) of this section shall include:

(a) A description of any injunction or administrative order, including a denial to engage in a regulated activity by a state or federal authority that had jurisdiction over the applicant, its affiliates, and its employees;

(b) A conviction of a misdemeanor involving fraudulent dealings or moral turpitude or relating to any aspect of the insurance industry, the mortgage industry, the securities industry, or any other activity pertaining to financial services;

(c) Any felony conviction; and

(d) A beneficial interest in an affiliated industry business.

(c) Each applicant shall pay a reasonable annual licensure or certification fee as established by rule of the commissioner.

(d) Each license or certification issued by the commissioner under this subchapter expires two (2) years after the date the license or certification is issued unless otherwise renewed, surrendered, or revoked.

(e) A license or certification issued under this subchapter is not transferable.

(f) To assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions that the commissioner and the nongovernmental business may consider appropriate, including the collection of the annual fee for licensure or certification of a navigator, guide, certified application counselor, or certified licensed producer.

History. Acts 2013, No. 1439, § 1; 2015, No. 1115, § 30; 2017, No. 283, § 11; 2019, No. 910, § 2349.

Amendments. The 2017 amendment, in (d), substituted "two (2) years after the date the license or certification is issued" for "at the close of business on September

30 of the calendar year" and inserted "renewed".

The 2019 amendment substituted "Adult Education Section of the Division of Workforce Services" for "Department of Career Education" in (a)(2).

23-64-608. License renewal.

(a) A licensee shall submit an application for renewal of a license or certification issued under this subchapter in a form prescribed by the Insurance Commissioner.

(b) An applicant for a license or certification renewal is required to complete continuing education as prescribed by rule of the commissioner.

(c) Each licensee shall pay a reasonable annual licensure or certification fee as established by rule of the commissioner.

History. Acts 2013, No. 1439, § 1.

23-64-609. Additional licensee duties.

(a) A licensee is subject to the insurance laws of this state, including those concerning privacy, market conduct, and unfair trade practices acts.

(b) A licensee shall:

(1) Comply with other consumer protection and market conduct standards that the Insurance Commissioner considers necessary; and

(2) Counsel enrollees in the health insurance marketplace in this state about options in Medicaid, the federal Children's Health Insurance Program, and other health insurance coverage.

History. Acts 2013, No. 1439, § 1.

23-64-610. Prohibited activities.

(a) Except for a certified licensed producer, a licensee shall not:

(1) Receive compensation directly or indirectly from any health insurer;

(2) Engage in an activity that requires licensing as a residential insurance producer under the Producer Licensing Model Act, § 23-64-501 et seq.; or

(3) Recommend a particular plan or advise consumers about which plan to choose.

(b) A licensee shall not engage in improper conduct, commit fraud, or violate marketplace and consumer protection requirements of this state.

History. Acts 2013, No. 1439, § 1.

23-64-611. Disciplinary authority.

(a) The Insurance Commissioner by order may deny, suspend, revoke, or refuse to issue or renew a license of a licensee or applicant under this subchapter or may restrict or limit the activities of a licensee if the commissioner finds that:

(1) The order is in the public interest; and

(2) A licensee or applicant:

(A) Has filed an application for an initial license or a renewal of a license that as of its effective date or as of any date after the filing of the application, contains an omission or statement that in light of the circumstances under which it was made is false or misleading with respect to any material fact;

(B) Has violated or failed to comply with this subchapter, the insurance laws of this state, any rule adopted by the commissioner, or any order of the commissioner issued under this subchapter;

(C) Has pleaded guilty or nolo contendere to or has been found guilty in a domestic, foreign, or military court of:

(i) A felony;

(ii) An offense involving breach of trust, moral turpitude, money laundering, or fraudulent or dishonest dealing; or

(iii) An offense involving any aspect of the insurance business, the mortgage industry, the securities industry, or any other activity pertaining to financial services;

(D) Is permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the insurance business, the mortgage industry, the securities industry, or any other activity pertaining to financial services;

(E) Is the subject of an order of the commissioner:

(i) Denying, suspending, revoking, restricting, or limiting a license issued under the insurance laws of this state; or

(ii) Directing the licensee or applicant to cease and desist an activity regulated by the commissioner;

(F) Is the subject of an order, including a denial, suspension, or revocation of authority to engage in a regulated activity by another

state or federal authority to which the licensee or applicant is, has been, or has sought to be subject, entered in the past five (5) years, including without limitation the insurance industry;

(G)(i) Has failed to pay the proper fees as established by rule of the commissioner.

(ii) The commissioner may enter a denial order against a licensee or applicant under subdivision (a)(2)(G)(i) of this section if the licensee or applicant fails to pay the proper fees as established by rule of the commissioner, but the denial order shall be vacated by the commissioner if the fees are paid;

(H) Has engaged in fraudulent, coercive, or dishonest practices or demonstrated incompetence, untrustworthiness, lack of good personal or business reputation, or financial irresponsibility;

(I) Has forged another's name to an application for insurance or to any document related to an insurance transaction;

(J) Has improperly used notes or any other reference material to complete an examination for an insurance license;

(K) Has failed to provide a written response within thirty (30) days after receipt of a written inquiry from the commissioner or the commissioner's designee concerning transactions unless the commissioner waives the requirement of a timely response in writing;

(L) Has failed to comply with an administrative or court order imposing a child support obligation;

(M) Has failed to pay state income tax or comply with an administrative or court order directing payment of state income tax;

(N) Has refused to be examined or to produce an account, record, or file for examination at the request of the commissioner or the commissioner's designee; or

(O) Has failed to cooperate with the commissioner in an investigation.

(b) The commissioner by order may:

(1)(A) Impose a civil penalty on a licensee for a violation of this subchapter, the insurance laws of this state, a rule under this subchapter, or an order of the commissioner.

(B) The civil penalty shall not exceed ten thousand dollars (\$10,000) for each violation under subdivision (b)(1)(A) of this section by a licensee;

(2) Summarily postpone or suspend the license of a licensee pending a final determination of a proceeding under this section; and

(3) Change or vacate an order or extend it until a final determination of a proceeding under this section if a hearing is requested or ordered by the commissioner.

(c) On entering an order under subdivision (b)(1) or subdivision (b)(2) of this section, the commissioner shall:

(1) Promptly notify the licensee by sending notice of the order and the reasons for issuing the order to the address of the licensee on file with the commissioner by first class mail, postage prepaid; and

(2)(A) Schedule a hearing under § 23-61-301 et seq. if a licensee contests the order.

(B) The licensee may contest an order entered under subdivision (b)(1) or subdivision (b)(2) of this section by delivering a written request for a hearing to the commissioner within thirty (30) days after the date on which notice of the order is sent by the commissioner.

(C)(i) The hearing shall be held within thirty (30) days after the commissioner receives a timely written request for a hearing.

(ii) At the request of the licensee, the hearing may be postponed for a reasonable amount of time.

(D) If a licensee does not request a hearing and the commissioner does not order a hearing, the order shall remain in effect until the order is modified or vacated by the commissioner.

(d) The commissioner by order may cancel a license or application if the commissioner finds that a licensee or applicant:

(1) Is no longer in existence;

(2) Has stopped doing business as a licensee;

(3) Is subject to an adjudication of mental incompetence or to the control of a committee, conservator, or guardian; or

(4) Cannot be located after a reasonable search by the commissioner.

(e)(1) In addition to other powers under this subchapter, on finding that an action of a person is in violation of this subchapter, the commissioner may summarily order the person to cease and desist the prohibited action.

(2) On entering the order under subdivision (e)(1) of this section, the commissioner shall:

(A) Promptly notify the person by sending notice of the order and the reasons for issuing the order to the last known address of the person by first class mail, postage prepaid; and

(B)(i) Schedule a hearing under § 23-61-301 et seq. if the person contests the order.

(ii) The person may contest an order entered under subdivision (e)(1) of this section by delivering a written request for a hearing to the commissioner within thirty (30) days after the date on which notice of the order is sent by the commissioner.

(iii)(a) The hearing shall be held within thirty (30) days after the commissioner receives a timely written request for a hearing.

(b) At the request of the person, the hearing may be postponed for a reasonable amount of time.

(iv) If a person does not request a hearing and the commissioner does not order a hearing, the order shall remain in effect until it is modified or vacated by the commissioner.

(3)(A) A person is subject to a civil penalty of up to twenty-five thousand dollars (\$25,000) for each violation of the commissioner's cease and desist order committed after entry of the order if:

(i) The person under the cease and desist order fails to appeal the order under § 23-61-307 or if the person appeals and the appeal is denied or dismissed; and

(ii) The person continues to engage in the prohibited action in violation of the commissioner's order.

(B) The commissioner may file an action requesting the civil penalty under subdivision (e)(3)(A) of this section with the Pulaski County Circuit Court or another court of competent jurisdiction.

(C) The penalties of this section apply in addition to, but not instead of, other applicable law to a person for the person's failure to comply with an order of the commissioner.

(f) Unless otherwise provided, an action, hearing, or other proceeding under this subchapter is governed by § 23-61-301 et seq.

(g) If the commissioner has grounds to believe that a licensee has violated this subchapter or that facts exist that would be the basis for an order against a licensee, the commissioner or the commissioner's designee may investigate or examine the business of the licensee and examine the books, accounts, records, and files of a licensee relating to the complaint or matter under investigation.

(h)(1) The commissioner or the commissioner's designee may:

(A) Administer oaths and affirmations;

(B) Issue subpoenas to require the attendance of and to take testimony of a person whose testimony the commissioner considers relevant to the licensee's business; and

(C) Issue subpoenas to require the production of the books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner considers relevant or material to the inquiry.

(2)(A) When there is contumacy by or refusal to obey a subpoena issued to a licensee or applicant, the Pulaski County Circuit Court, on application by the commissioner, may issue an order requiring the person to appear before the commissioner or the commissioner's designee to produce evidence if so ordered or to give evidence touching the matter under investigation or in question.

(B) Failure to obey the order of the court may be punished by the court as a contempt of court.

(3) The assertion that the testimony or evidence before the commissioner may tend to incriminate or subject a person to a penalty or forfeiture shall not under § 23-61-302 excuse the person from:

(A) Attending and testifying;

(B) Producing any document or record; or

(C) Obeying the subpoena of the commissioner or the commissioner's designee.

(i) From time to time and with or without cause, the commissioner may conduct examinations of the books and records of a licensee or applicant to determine the compliance with this subchapter and the rules adopted under this subchapter.

(j) This section does not prohibit or restrict the informal disposition of a proceeding or allegations that may give rise to a proceeding by stipulation, settlement, consent, or default instead of a formal or informal hearing on the allegations or in place of the sanctions authorized by this section.

(k)(1) If it appears on sufficient grounds or evidence satisfactory to the commissioner that a person has engaged in or is about to engage in an act or practice that violates this subchapter, the commissioner may:

(A) Refer the evidence that is available concerning violations of this subchapter or a rule or order issued under this subchapter to the prosecuting attorney or regulatory agency that with or without the referral may otherwise begin criminal or regulatory proceedings under this subchapter; and

(B)(i) Summarily order the person to stop the act or practice under subsections (b) and (e) of this section and apply to the Pulaski County Circuit Court to enjoin the act or practice or to enforce compliance with this subchapter, rule, or order issued under this subchapter, or both.

(ii) The commissioner, without issuing a cease and desist order, may apply directly to the Pulaski County Circuit Court for injunctive or other relief.

(2) On proper showing, the court shall grant a permanent or temporary injunction, restraining order, or writ of mandamus.

(3) The commissioner may also seek and on proper showing the appropriate court shall grant any other ancillary relief that may be in the public interest, including:

(A) The appointment of a receiver, temporary receiver, or conservator;

(B) A declaratory judgment;

(C) An accounting;

(D) Disgorgement;

(E) Assessment of a fine of not more than ten thousand dollars (\$10,000) for each violation; and

(F) Any other relief as may be appropriate in the public interest.

(4) The court shall not require the commissioner to post a bond.

History. Acts 2013, No. 1439, § 1.

23-64-612. Authority — Grants and contracts.

(a) The health insurance marketplace in this state may accept grants or contract with a governmental or nongovernmental entity that uses navigators or guides on the conditions the health insurance marketplace finds to be in the best interest of the citizens of this state if the governmental or nongovernmental entity:

(1) Has a physical business location to conduct business with this state and its service area;

(2) Is considered to be competent, trustworthy, financially responsible, and of a good business reputation;

(3) Continues the qualifications under subdivision (a)(2) of this section during the contract;

(4) Requires the members of management of the governmental or nongovernmental entity to complete instruction in health benefit plans or health insurance, the provisions of the federal act for a health

insurance marketplace in this state, and the medical assistance programs of this state through a training program approved by the Insurance Commissioner for the required minimum hours; and

(5) Furnishes to the commissioner information concerning the identity and background of the members of management of the governmental or nongovernmental entity, including criminal and regulatory background checks.

(b) Each nongovernmental business entity shall pay a reasonable annual licensure fee that is established by rule.

(c) A grant or contract under this section is not transferable.

History. Acts 2013, No. 1439, § 1.

23-64-613. Rules.

(a) The Insurance Commissioner may promulgate rules to implement this subchapter.

(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under the federal act.

History. Acts 2013, No. 1439, § 1.

23-64-614. Relation to other laws.

(a) This subchapter is amendatory to the Arkansas Insurance Code.

(b) Provisions of the Arkansas Insurance Code that are not in conflict with this subchapter apply to this subchapter.

(c) This subchapter and actions taken by the health insurance marketplace in this state under this subchapter do not preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.

(d) Except as expressly provided to the contrary in this subchapter, a health insurer offering a qualified health plan in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

History. Acts 2013, No. 1439, § 1; 2019, 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

Publisher's Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148 is codified as set out in the note following § 23-60-101.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (d).

CHAPTER 65

UNAUTHORIZED INSURERS AND SURPLUS LINES

SUBCHAPTER.

1. GENERAL PROVISIONS.

3. SURPLUS LINES INSURANCE LAW.

SUBCHAPTER

4. MULTISTATE AGREEMENTS OR COMPACTS.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

23-65-101. Unauthorized insurance transactions prohibited.

23-65-101. Unauthorized insurance transactions prohibited.

(a)(1) No person or entity in this state shall act as agent or broker for or otherwise represent or aid any insurer, health maintenance organization, multiple employer welfare arrangement, multiple employer trust, association, or any other person or entity in the solicitation, negotiation, or effectuation of insurance, inspection of risks, fixing of rates, investigation or adjustment of losses, collection of premiums, or in any other manner in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state if that person or entity is not authorized or licensed by the State Insurance Department for those purposes.

(2)(A) No person or entity shall act as a producer, adjuster, or consultant without first obtaining appropriate licensure or registration as required by the insurance laws of this state for the transaction of insurance with respect to subjects of insurance or self-insurance resident, located, or to be performed in this state.

(B) No person or entity shall act as a multiple employer trust or multiple employer welfare arrangement without first obtaining appropriate registration or licensing as required by § 23-92-101.

(C) No person or entity shall act as a third-party administrator for a multiple employer trust, multiple employer welfare arrangement, collectively bargained trust, self-insurance plan, or any other plan providing accident and health insurance benefits to the citizens of this state without first obtaining appropriate registration as required by § 23-92-201 et seq.

(D) Any producer who knows or has reason to know that a health plan is not licensed in accordance with the Arkansas Insurance Code shall immediately report the health plan to the department.

(b)(1)(A) The Insurance Commissioner may summarily order a person or entity to cease and desist from an act or practice when the commissioner has reason to believe that the person or entity has not complied with the requirements of this section or any other provision of the Arkansas Insurance Code.

(B) Upon the entry of the cease and desist order, the commissioner shall promptly notify the person or entity named:

(i) That the order has been entered;

(ii) The reasons for the order; and

(iii) Of the person's or entity's right to a hearing on the order.

(2)(A) A hearing shall be held on the written request of the person or entity named in the cease and desist order if the commissioner

receives the request within thirty (30) days of the date of the entry of the order or if otherwise ordered by the commissioner.

(B) If no hearing is requested and none is ordered by the commissioner, the order will remain in effect until it is modified or vacated by the commissioner.

(C) If a hearing is requested or ordered and after notice of an opportunity for hearing, the commissioner may affirm, modify, or vacate the cease and desist order.

(D) The person or entity named in the cease and desist order shall have the burden of proving:

(i) That the actions, methods, or practices described in the order are not in violation of the Arkansas Insurance Code; and

(ii) The grounds upon which the commissioner should modify or vacate an order issued under this section.

(3)(A) After issuance of an order under subdivision (b)(1)(B) of this section, the commissioner may apply to Pulaski County Circuit Court to temporarily or permanently enjoin the act or practice and to enforce compliance with the Arkansas Insurance Code or any rule or order under the Arkansas Insurance Code.

(B) However, the commissioner may apply directly to Pulaski County Circuit Court for a temporary or permanent injunction under subdivision (b)(3)(A) of this section.

(C) Upon a proper showing, the court shall enter a permanent or temporary injunction, restraining order, or writ of mandamus.

(D) The commissioner shall not be required to post a bond.

(c) The commissioner may also seek and the appropriate court may grant any other ancillary relief which may be in the public interest, including the appointment of a receiver, temporary receiver, conservator, or declaratory judgment, obtaining an accounting, disgorgement, assessment of a fine, or other relief as may be appropriate in the public interest.

(d) This section does not prohibit or restrict the informal disposition of a proceeding by stipulation, settlement, consent, or default.

(e) Any insurance producer licensed in this state, or any other person, who knowingly sells, solicits, or negotiates a product of an unauthorized person or entity in violation of this section or who knowingly represents or aids an unauthorized person or entity in violation of this section shall be guilty of a Class D felony.

(f) Any insurance producer licensed in this state, or any other person, who sells, solicits, or negotiates a product of an unauthorized person or entity in violation of this section or who represents or aids an unauthorized person or entity in violation of this section may be personally liable for all damages caused by the unauthorized person or entity, including claims unpaid by the unauthorized person or entity.

(g) Any person or entity who violates or otherwise fails to comply with a cease and desist order of the commissioner under this section while that order is in effect may be subject, at the discretion of the commissioner, to any one (1) or more of the following:

(1) A monetary penalty of not more than ten thousand dollars (\$10,000);

(2) Suspension or revocation of the person's or entity's license or registration; and

(3) Upon the commissioner's petition filed in Pulaski County Circuit Court and upon good cause shown, that court may order injunctive relief.

(h) The following shall be applicable to hearings held, orders issued, and penalties levied by the commissioner under this section:

(1) The provisions of § 23-61-301, as to witnesses and evidence;

(2) Section 23-61-302, as to immunity from prosecution;

(3) The provisions of §§ 23-61-303 — 23-61-305, as to hearings;

(4) The provisions of §§ 23-61-306 and 23-61-307, as to orders on hearings and appeals of orders;

(5) The provisions of § 23-66-210(a)(1), as to monetary penalties; and

(6) The provisions of § 23-66-212, as to judicial review of cease and desist orders.

(i) The commissioner may promulgate such reasonable rules as are necessary to carry out the provisions of this section.

(j)(1) The commissioner shall have the power to examine and investigate the affairs of every person or entity suspected of engaging in activities which are prohibited by this section or by any other provision of the Arkansas Insurance Code.

(2) All licensees of the commissioner shall assist the commissioner in examinations and investigations conducted under this section.

(k) The powers vested in the commissioner by this section shall be additional to any other powers to enforce any penalties, fines, or forfeitures authorized by law or other provisions of the Arkansas Insurance Code with respect to activities that are prohibited by this section or the Arkansas Insurance Code.

(l) This section shall not apply to:

(1) Acceptance of service of process by the commissioner under § 23-65-203; and

(2) Surplus lines insurance and other transactions as to which a certificate of authority is not required of an insurer, as stated in § 23-63-201.

History. Acts 1959, No. 148, § 181; A.S.A. 1947, § 66-2901; Acts 1987, No. 400, § 1; 1991, No. 1123, § 2; 1993, No. 901, § 32; 2001, No. 1603, § 22; 2003, No. 516, § 5; 2005, No. 1697, §§ 10, 11; 2017, No. 283, § 12; 2019, No. 315, § 2661.

Amendments. The 2017 amendment substituted "Section 23-61-302" for "The provisions of §§ 23-61-302 and 23-66-214" in (h)(2).

The 2019 amendment deleted "and regulations" following "rules" in (i).

SUBCHAPTER 3 — SURPLUS LINES INSURANCE LAW

SECTION.

23-65-302. Exceptions.

23-65-303. Insurer not admitted.

23-65-306. Brokers' reports.

23-65-310. Surplus lines in solvent insurers.

SECTION.

23-65-315. Tax on brokers.

23-65-317. Revocation of broker's license.

23-65-320. Domestic surplus lines insurers.

23-65-302. Exceptions.

This subchapter does not apply to reinsurance or to the following types of insurance when placed by licensed agents or brokers of this state:

- (1) Wet marine and foreign trade insurance;
- (2) Insurance on subjects that are:
 - (A) Located, resident, or to be performed outside this state; or
 - (B) On vehicles or aircraft principally garaged outside this state;
- (3) Insurance on property or operation of railroads engaged in interstate commerce;
- (4) Accident and health coverage; and
- (5) Insurance of aircraft:
 - (A) Owned or operated by manufacturers of aircraft;
 - (B) Operated in scheduled interstate flight;
 - (C) Cargo; or
 - (D) Against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of the aircraft.

History. Acts 1959, No. 148, § 205; in the introductory language, substituted A.S.A. 1947, § 66-2925; Acts 2011, No. "does not" for "shall not" and "types of 1055, § 2; 2021, No. 367, § 15. insurance" for "insurances"; and inserted

Amendments. The 2021 amendment, (4) and redesignated former (4) as (5).

23-65-303. Insurer not admitted.

(a) The permission granted in this law to place any insurance in a nonadmitted insurer shall not be deemed or construed to authorize that insurer to otherwise transact an insurance business in this state. Further, this limited permission shall not be deemed or construed so as to exempt nonadmitted insurers from the principles of the common law of insurance or from the same statutory and common law penalties that may attach in favor of insureds in the event of disputes or litigation between insureds and admitted insurers.

(b) A contract of insurance carried out by an unauthorized insurer in violation of this subchapter is voidable at the instance of the insured.

History. Acts 1959, No. 148, § 193; 118, § 1; 2011, No. 1055, § 2; 2013, No. A.S.A. 1947, § 66-2913; Acts 1993, No. 355, § 7.

23-65-306. Brokers' reports.

(a) At the time of the procuring of surplus lines insurance in this state, when this state is considered the home state of the insured, the surplus lines broker shall file a report with the Insurance Commissioner within sixty (60) days following the end of the calendar quarter stating the facts referenced in §§ 23-65-313 and 23-65-314 and any additional information the commissioner shall require.

(b) Reports filed under this section are not subject to public inspection unless the commissioner determines that the public interest or the welfare of the filing broker requires otherwise.

History. Acts 1959, No. 148, § 191; 1979, No. 731, § 2; 1985, No. 804, § 9; A.S.A. 1947, § 66-2911; Acts 2001, No. 1555, § 4; 2011, No. 1055, § 2; 2019, No. 521, § 18.

Amendments. The 2019 amendment substituted "reports" for "affidavits" in the section heading; added "file a report with

the Insurance Commissioner within sixty (60) days following the end of the calendar quarter stating the facts referenced in §§ 23-65-313 and 23-65-314 and any additional information the commissioner shall require" in (a); deleted (a)(1) through (a)(4); and substituted "Reports" for "Affidavits or reports" in (b).

23-65-310. Surplus lines in solvent insurers.

(a) A surplus lines broker shall place surplus lines insurance only with insurers that have been approved by the Insurance Commissioner.

(b)(1) The commissioner may maintain a list of approved foreign and alien surplus lines insurers in addition to those alien insurers maintaining status on the current National Association of Insurance Commissioners' nonadmitted insurers' quarterly listing.

(2) The approved list shall not contain:

(A) An insurer that is not licensed in at least one (1) state of the United States for the kind of insurance involved;

(B) A stock insurer having capital and surplus amounting to less than three million dollars (\$3,000,000);

(C) A type of insurer, other than stock insurers, having surplus of less than three million dollars (\$3,000,000);

(D)(i) An alien insurer, unless:

(a) The insurer has an established and effective trust fund within the United States administered by a recognized financial institution and held for the benefit of its policyholders; and

(b) The trust fund is in the amount of not less than one million dollars (\$1,000,000).

(ii)(a) The broker may place casualty insurance with an alien insurer or a pool of alien insurers having combined capital and surplus of five million dollars (\$5,000,000) or more, so long as the insured signs an affidavit accepting the insurance.

(b) The affidavit shall include a statement that the insurance is not available to him or her elsewhere.

(iii) The alien insurer shall:

(a) Annually report the location and balance of the trust fund to the commissioner as the commissioner prescribes; and

(b) Report to the commissioner any change in the location of the trust fund;

(E) An insurer owned or controlled by a political sovereign or an agency of a political sovereign; or

(F)(i) An insurer that does not maintain on deposit under § 23-63-901 et seq. eligible securities having a market value at all times of at least one hundred thousand dollars (\$100,000) conditioned on the payment of creditors or obligees of the insurer in this state and the prompt payment of all claims arising and accruing to any persons during the term of the securities under a policy issued by the insurer.

(ii) This subdivision (b)(2)(F) does not apply to foreign and alien surplus lines insurers as of July 21, 2011, if the requirements of the Nonadmitted and Reinsurance Reform Act of 2010, Pub. L. No. 111-203, as it existed on January 1, 2013, are met.

(c) Upon receipt of a written request from the commissioner, an insurer shall promptly furnish to the commissioner information concerning its transactions or affairs.

History. Acts 1959, No. 148, § 196; § 66-2916; Acts 1989, No. 772, §§ 7, 8; 1961, No. 466, § 10; 1973, No. 66, § 7; 2011, No. 1055, § 2; 2013, No. 355, §§ 8, 1977, No. 789, § 5; 1981, No. 809, § 4; 9. 1983, No. 522, §§ 25, 26; A.S.A. 1947,

23-65-315. Tax on brokers.

(a) No later than sixty (60) days following the end of the calendar quarter in which surplus lines insurance was procured, the surplus lines broker shall remit to the Treasurer of State through the Insurance Commissioner a tax of four percent (4%) on the direct premiums written, less return premiums and exclusive of sums collected to cover state or federal taxes, on surplus lines insurance subject to tax transacted by the surplus lines broker during the preceding calendar quarter for the privilege of transacting business as a surplus lines broker in this state.

(b) The commissioner may participate in a multistate agreement or enter into a compact for the purpose of reporting, collecting, and apportioning surplus lines insurance premium taxes.

(c) If a surplus lines insurance policy covers risks or exposures only partially in this state and the commissioner has entered into an agreement with other states for the apportionment of premium taxes for multistate risks, the tax payable by the surplus lines broker shall be computed and paid on the proportion of the premium that is properly allocable to the risks or exposures located in this state according to the terms of the agreement.

History. Acts 1959, No. 148, § 201; in (a), substituted "the end of the calendar A.S.A. 1947, § 66-2921; Acts 1987, No. quarter" for "the end of the month" and 456, § 12; 2001, No. 1555, § 8; 2011, No. substituted "preceding calendar quarter" 1055, § 2; 2019, No. 521, § 19. for "preceding months as shown by his or

Amendments. The 2019 amendment, her affidavit filed with the commissioner".

23-65-317. Revocation of broker's license.

(a) The Insurance Commissioner shall revoke a surplus lines broker's license:

(1) If the broker fails to file his or her quarterly statement or fails to remit the tax as required by law;

(2) If the broker fails to maintain an office, keep records, or allow the commissioner to examine his or her records as required by law; or

(3) For any cause for which an agent's license may be revoked.

(b) The commissioner may suspend or revoke a license whenever he or she deems the suspension or revocation to be for the best interest of the people of this state.

(c) The procedures provided by § 23-64-218 for the suspension or revocation of an agent's license shall be applicable to suspension or revocation of a surplus lines broker's license.

(d) A broker whose license has been revoked shall not be licensed within one (1) year thereafter or until payment of fines or delinquent taxes.

History. Acts 1959, No. 148, § 203; 1555, § 9; 2011, No. 1055, § 2; 2013, No. A.S.A. 1947, § 66-2923; Acts 2001, No. 1133, § 8.

23-65-320. Domestic surplus lines insurers.

(a) A domestic insurer possessing policyholder surplus of at least twenty million dollars (\$20,000,000) may be:

(1) Designated as a domestic surplus lines insurer with the written approval of the Insurance Commissioner; and

(2) Allowed to write surplus lines insurance in any jurisdiction in which it is eligible.

(b) A domestic surplus lines insurer is:

(1) Deemed a nonadmitted surplus lines insurer in the State of Arkansas; and

(2) Deemed a nonadmitted surplus lines insurer under the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203.

(c) A domestic surplus lines insurer is not subject to:

(1) The Arkansas Property and Casualty Insurance Guaranty Act, § 23-90-101 et seq.; or

(2) The Arkansas Life and Health Insurance Guaranty Association Act, § 23-96-101 et seq.

(d) A surplus lines broker that obtains surplus lines insurance from a domestic surplus lines insurer shall comply with § 23-65-315.

(e) Unless specifically exempt, the insurance laws of this state regarding financial and solvency requirements apply to a domestic surplus lines insurer.

History. Acts 2011, No. 332, § 1; 2013, No. 157, § 1.

SUBCHAPTER 4 — MULTISTATE AGREEMENTS OR COMPACTS

SECTION.

23-65-403. Committees' approval of agreements or compacts required.

23-65-403. Committees' approval of agreements or compacts required.

A multistate agreement or compact entered into by the Insurance Commissioner shall be:

- (1) Considered by the Senate Committee on Insurance and Commerce and the House Committee on Insurance and Commerce; and
- (2) Reviewed and approved by the Legislative Council.

History. Acts 2011, No. 1055, § 3; 2015, No. 1258, § 19.

A.C.R.C. Notes. Acts 2015, No. 1258, § 1, provided: "LEGISLATIVE FINDINGS. The General Assembly finds:

"(1) Amendment 92 to the Arkansas Constitution states in part: "The General Assembly may provide by law for the review by a legislative committee of administrative rules promulgated by a state agency before the administrative rules become effective; and that administrative rules promulgated by a state agency shall not become effective until reviewed and approved by the legislative committee charged by law with the review of administrative rules under subdivision (a)(1) of this section";

"(2) As Amendment 92 does not define the term "state agency", the General Assembly may establish a definition by law

as part of its implementation of Amendment 92;

"(3) The General Assembly at this time wishes to exclude the Arkansas State Game and Fish Commission, the State Highway Commission, the Arkansas State Highway and Transportation Department, and institutions of higher education from the definition of "state agency" applied to the implementation of Amendment 92; and

"(4) The General Assembly or the Legislative Council reserve the right to amend the definition of "state agency" in the future to include one (1) or all of the Arkansas State Game and Fish Commission, the State Highway Commission, the Arkansas State Highway and Transportation Department, and institutions of higher education."

CHAPTER 66

TRADE PRACTICES

SUBCHAPTER.

2. TRADE PRACTICES ACT.
3. MISCELLANEOUS PROHIBITED PRACTICES.
4. HOME SERVICE ACT.
5. FRAUDULENT INSURANCE ACTS PREVENTION.
6. INSURANCE SALES CONSUMER PROTECTION ACT.

SUBCHAPTER 2 — TRADE PRACTICES ACT

SECTION.	SECTION.
23-66-206. Unfair methods of competition and unfair or deceptive acts or practices defined. [Effective until July 1, 2022.]	23-66-207. Rules to identify prohibited methods of competition, acts, or practices.
23-66-206. Unfair methods of competition and unfair or deceptive acts or practices defined. [Effective July 1, 2022.]	23-66-214. [Repealed.]
	23-66-215. Penalty for late payment of claims by health carriers.

Effective Dates. Acts 2021, No. 994,
§ 2: July 1, 2022.

23-66-202. Purpose.

RESEARCH REFERENCES

Ark. L. Rev. Nathan Price Chaney, The Arkansas Deceptive Trade Practices Act: The Arkansas Supreme Court Should Adopt the Specific-Conduct Rule, 67 Ark. L. Rev. 299 (2014).

23-66-206. Unfair methods of competition and unfair or deceptive acts or practices defined. [Effective until July 1, 2022.]

The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) “Boycott, coercion, and intimidation” means entering into any agreement to commit or, by any concerted action, committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(2) “Churning of business” means a situation in which the licensee replaces an existing policy of life insurance or accident and health insurance, or both, and that replacement is:

(A) Not in accordance with § 23-66-307; or

(B) Without objective demonstration by the licensee of the purpose of replacing the policy for the benefit and betterment of the insured;

(3) “Defamation” means making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or of any pamphlet, circular, article, or literature that is false or maliciously critical of or derogatory to the financial condition of any person and that is calculated to injure that person;

(4)(A) “Failure to maintain complaint handling procedures” means failing to adopt and implement reasonable standards for the prompt handling of complaints received by the person from insureds or

claimants, or from the Insurance Commissioner on behalf of insureds or claimants, and failing to keep a record of the complaints received.

(B) A complete complaints register of all complaints that the person has received shall be maintained for the current year plus five (5) calendar years. This complaints register shall indicate:

- (i) The total number of complaints;
- (ii) The classification of complaints by line of insurance;
- (iii) The nature of each complaint;
- (iv) The disposition of each complaint;
- (v) The time it took to process each complaint; and
- (vi) Such other information as the commissioner may reasonably require by way of rules.

(C) As used in this subdivision (4), "complaint" means any written communication primarily expressing a grievance;

(5) "Failure to maintain conflict of interest procedures" means failing to adopt and implement on or before the next financial or market conduct examination conducted by the commissioner on and after passage of this act and thereafter maintain written conflict of interest procedures and provisions, in form and format satisfactory to the commissioner, designed to identify and resolve promptly any general or pecuniary conflicts of interest as to officers, directors, managers, supervisors, and other key personnel of domestic insurers, including, but not limited to, domestic stock and mutual insurers, domestic stipulated premium insurers, domestic mutual assessment life and disability insurers, domestic health maintenance organizations, domestic farmers' mutual aid associations, domestic hospital or medical service corporations, and domestic fraternal benefit societies;

(6) "False information and advertising generally" means making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio or television station or in any other way an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business that is untrue, deceptive, or misleading;

(7) "False statements and entries" means:

(A) Filing with any supervisory or other public official or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of a person with intent to deceive; and

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of the person in any book, report, or statement of that person;

(8) "Misrepresentation and false advertising of insurance policies" means making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustrations, circular, statement, sales presentation, omission, or comparison, which:

(A) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;

(C) Makes any false or misleading statements to the dividends or share of surplus previously paid on any insurance policy;

(D) Is misleading or is a misrepresentation as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates;

(E) Uses any name or title of any insurance policy or class of insurance policies, misrepresenting the true nature thereof;

(F) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(G) Is a misrepresentation for the purpose of effectuating a pledge or assignment of or effecting a loan against any insurance policy; or

(H) Misrepresents any insurance policy as being shares of stock;

(9)(A) "Policy cancellations" means cancellations of insurance coverage on a property or casualty risk that has been in force over sixty (60) days or after the effective date of a renewal policy or an annual anniversary date unless the cancellation is based upon at least one (1) of the following reasons:

(i) Nonpayment of premium;

(ii) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy;

(iii) The occurrence of a material change in the risk that substantially increases any hazard insured against after policy issuance;

(iv) Violation of any local fire, health, safety, building, or construction regulation or ordinances with respect to any insured property or the occupancy of the property that substantially increases any hazard insured against under the policy;

(v) Nonpayment of membership dues in those cases in which the bylaws, agreements, or other legal instruments of the insurer issuing the policy require payment as a condition of the issuance and maintenance of the policy; or

(vi) A material violation of a material provision of the policy.

(B) Cancellations of property and casualty policies shall only be effective when notice of cancellation is mailed or delivered by the insurer to the named insured and to any lienholder or loss payee named in the policy at least twenty (20) days prior to the effective date of cancellation. However, when cancellation is for nonpayment of premium, at least ten (10) days' notice of cancellation accompanied by the reason for cancellation shall be given.

(C) The provisions of this subdivision (9) shall not be applicable to any policy providing coverage for workers' compensation or employers' liability or to any policy providing coverage for personal automobile liability, automobile physical damage, or automobile collision, or any combination thereof;

(10)(A) "Rebates", except as otherwise expressly provided by law, means the act of knowingly:

(i) Permitting or offering to make or making any life, health, and annuity insurance contract, or agreement as to the contract, other than as plainly expressed in the insurance contract issued thereon;

(ii) Paying, allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance contract any rebate of premiums payable on the contract or any special favor or advantage in the dividends or other benefits thereon or any valuable consideration or inducement whatever not specified in the contract; or

(iii) Giving, selling, or purchasing or offering to give, sell, or purchase as inducement to the insurance contract or in connection with the contract any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership or any dividends or profits accrued thereon or anything of value whatsoever not specified in the insurance contract.

(B) Subdivision (10)(A) or subdivision (14) of this section shall not be construed as including within "rebates" or "unfair discrimination" any of the following practices:

(i) In the case of any contract of life insurance or life annuity, the paying of bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that those bonuses or abatement of premiums shall be fair and equitable for policyholders and for the best interests of the company and its policyholders;

(ii) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(iii) Readjustment of the rate of premium for a group insurance policy based on the loss or expense under the policy at the end of the first or any subsequent policy year of insurance under the policy, which may be made retroactive only for the policy year;

(iv) Engaging in an arrangement that does not violate section 106 of the Bank Holding Company Act Amendments of 1970, 12 U.S.C. § 1972, as interpreted by the Board of Governors of the Federal Reserve System, or section 1464(q) of the Home Owners' Loan Act, 12 U.S.C. § 1461 et seq.; or

(v) Under a prior written agreement with a client paying total annual premiums, for all lines of business, of one hundred thousand dollars (\$100,000) or more, adjusting or refunding a part of a

consulting fee charged by a licensed insurance consultant based on commissions received by the consultant from insurance carriers;

(11) "Stock operations and advisory board contracts" means issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock, or other capital stock or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind that promise returns and profits as an inducement to insurance;

(12) "Underwriting: refusing certain risks" means refusing to issue or limiting the amount of coverage on a property or casualty risk based upon knowledge of an insurer's nonrenewal of the applicant's previous property or casualty policy or contract;

(13) "Unfair claims settlement practices" means committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(G) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

(H) Making claim payments to policyholders or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(I) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(J) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts of applicable law for denial of a claim or for the offer of a compromise settlement;

(K) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

(L) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(N) Failing to promptly settle claims, when liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and

(O) Requiring as a condition of payment of a claim that repairs must be made by a particular contractor, supplier, or repair shop;

(14) "Unfair discrimination" means:

(A) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such a contract;

(B) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium policy fees or rates charged for any policy or contract of accident and health insurance, or in the benefits payable thereunder, or in any of the terms or conditions of the contract, or in any other manner whatever;

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(i) The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained therein because of the age of the residential property unless:

(i) The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the marital status of the individual. However, nothing in this subdivision (14)(E) shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage or refusing to issue or refusing to renew any policy or contract of insurance solely because

the applicant or insured or any employee of either is mentally or physically impaired. However, this subdivision (14)(F) shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(G)(i) Refusing to insure or continue to insure an individual or risks solely because of the individual's race, color, creed, national origin, citizenship, status as a victim of domestic abuse, or sex.

(ii) As used in subdivision (14)(G)(i) of this section, "domestic abuse" means:

(a) Physical harm, bodily injury, or assault between family or household members;

(b) The infliction of fear of imminent physical harm, bodily injury, or assault between family members or household members; or

(c) Sexual conduct between family or household members, whether minors or adults, that constitutes a crime under the laws of this state; and

(H)(i)(a) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of coverage available for life insurance to an individual, or charging an individual a different rate for the same coverage, solely because of the individual's status as a living organ donor.

(b) With respect to other conditions, a person who is a living organ donor shall be subject to the same standards of sound actuarial principles as a person who is not a living organ donor.

(ii) As used in this subdivision (14)(H), "living organ donor" means a person who is a registered organ donor; and

(15)(A) "Unfair financial planning practices" includes an insurance producer:

(i)(a) Holding himself or herself out, directly or indirectly, to the public as a financial planner, investment adviser, consultant, financial counselor, or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters, if the insurance producer is, in fact, engaged only in the sale of policies.

(b) However, subdivision (15)(A)(i)(a) of this section does not preclude a person who holds some form of formal recognized financial planning or consultant certification or designation from using the certification or designation when the person is only selling insurance.

(c) Subdivision (15)(A)(i)(a) of this section does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation, or servicing of policies;

(ii)(a) Engaging in the business of financial planning without disclosing in writing to the client, prior to the execution of the agreement provided for in subdivision (15)(A)(iii) of this section, or solicitation of the sale of a product or service that:

(1) He or she is also an insurance salesperson; and

(2) A commission for the sale of an insurance product will be

received in addition to a fee for financial planning, if the sale involves a commission.

(b) The disclosure requirement under this subdivision (15)(A)(ii) may be met by including it in any written disclosure required by federal or state securities law; and

(iii)(a)(1) Charging fees other than commissions for financial planning by an insurance producer unless the fees are based upon a written agreement that is signed by the party to be charged in advance of the performance of the services under the agreement.

(2) A copy of the agreement under subdivision (15)(A)(iii)(a)(1) of this section must be provided to the party to be charged at the time the agreement is signed by the party.

(3) The services for which the fee is to be charged must be specifically stated in the agreement.

(4) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(5) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or financial consultant.

(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

(B) "Unfair financial planning practices" does not include funeral expense insurance and prepaid funeral benefits contracts.

History. Acts 1959, No. 148, § 212; 1963, No. 75, § 1; 1973, No. 41, § 2; 1975, No. 729, § 5; 1981, No. 809, §§ 6-9; A.S.A. 1947, § 66-3005; Acts 1987, No. 156, §§ 1, 2; 1987, No. 959, § 20; 1993, No. 1145, § 1; 1995, No. 178, § 1; 1997, No. 1000, § 4; 1999, No. 381, § 1; 2001, No. 1603, §§ 24, 25; 2003, No. 1747, §§ 2, 3; 2009, No. 619, § 1; 2011, No. 797, § 1; 2019, No. 244, § 1; 2019, No. 315, § 2662; 2019, No. 696, § 2.

Publisher's Notes. For text of section effective July 1, 2022, see the following version.

Amendments. The 2019 amendment by No. 244 added (14)(H).

The 2019 amendment by No. 315 substituted "rules" for "regulations" in (4)(B)(vi).

The 2019 amendment by No. 696 substituted "of the complaints received" for "thereof" in (4)(A); in the introductory language of (4)(B), deleted "since the date of its last examination" following "received" and inserted "for the current year plus five (5) calendar years"; and substituted "As used in" for "For purposes of" in (4)(C).

RESEARCH REFERENCES

Ark. L. Rev. Nathan Price Chaney, The Arkansas Deceptive Trade Practices Act: The Arkansas Supreme Court Should

Adopt the Specific-Conduct Rule, 67 Ark. L. Rev. 299 (2014).

23-66-206. Unfair methods of competition and unfair or deceptive acts or practices defined. [Effective July 1, 2022.]

The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) "Boycott, coercion, and intimidation" means entering into any agreement to commit or, by any concerted action, committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(2) "Churning of business" means a situation in which the licensee replaces an existing policy of life insurance or accident and health insurance, or both, and that replacement is:

(A) Not in accordance with § 23-66-307; or

(B) Without objective demonstration by the licensee of the purpose of replacing the policy for the benefit and betterment of the insured;

(3) "Defamation" means making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or of any pamphlet, circular, article, or literature that is false or maliciously critical of or derogatory to the financial condition of any person and that is calculated to injure that person;

(4)(A) "Failure to maintain complaint handling procedures" means failing to adopt and implement reasonable standards for the prompt handling of complaints received by the person from insureds or claimants, or from the Insurance Commissioner on behalf of insureds or claimants, and failing to keep a record of the complaints received.

(B)(i) A complete complaints register of all complaints that the person has received shall be maintained for the current year plus five

(5) calendar years.

(ii) The complaints register described in subdivision (4)(B)(i) of this section shall indicate:

(a) The total number of complaints;

(b) The classification of complaints by line of insurance;

(c) The nature of each complaint;

(d) The disposition of each complaint;

(e) The time it took to process each complaint; and

(f) Other information as the commissioner may reasonably require by way of rules.

(C) As used in this subdivision (4), "complaint" means any written communication primarily expressing a grievance;

(5) "Failure to maintain conflict of interest procedures" means failing to adopt and implement on or before the next financial or market conduct examination conducted by the commissioner on and after passage of this act and thereafter maintain written conflict of interest procedures and provisions, in form and format satisfactory to the commissioner, designed to identify and resolve promptly any general or pecuniary conflicts of interest as to officers, directors, managers, supervisors, and other key personnel of domestic insurers, including without limitation domestic stock and mutual insurers, domestic stipulated premium insurers, domestic mutual assessment life and disability insurers, domestic health maintenance organizations, domestic farmers' mutual aid associations, domestic hospital or medical service corporations, and domestic fraternal benefit societies;

(6) "False information and advertising generally" means making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio or television station or in any other way an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business that is untrue, deceptive, or misleading;

(7) "False statements and entries" means:

(A) Filing with any supervisory or other public official or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of a person with intent to deceive; and

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of the person in any book, report, or statement of that person;

(8) "Misrepresentation and false advertising of insurance policies" means making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustrations, circular, statement, sales presentation, omission, or comparison, that:

(A) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;

(C) Makes any false or misleading statements to the dividends or share of surplus previously paid on any insurance policy;

(D) Is misleading or is a misrepresentation as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates;

(E) Uses any name or title of any insurance policy or class of insurance policies, misrepresenting the true nature of the insurance policy;

(F) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(G) Is a misrepresentation for the purpose of effectuating a pledge or assignment of or effecting a loan against any insurance policy; or

(H) Misrepresents any insurance policy as being shares of stock;

(9)(A) "Rebates", except as otherwise expressly provided by law, means the act of knowingly:

(i) Permitting or offering to make or making any life, health, and annuity insurance contract, or agreement as to the contract, other than as plainly expressed in the insurance contract issued for the life, health, or annuity insurance policy;

(ii) Paying, allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance contract any rebate of premiums payable on the contract or any special favor or advantage in the dividends or other benefits under the insurance contract or any valuable consideration or inducement whatever not specified in the contract; or

(iii) Giving, selling, or purchasing or offering to give, sell, or purchase as inducement to the insurance contract or in connection with the contract any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership or any dividends or profits accrued under the insurance contract or anything of value whatsoever not specified in the insurance contract.

(B) Subdivision (9)(A) or subdivision (13) of this section shall not be construed as including within "rebates" or "unfair discrimination" any of the following practices:

(i) In the case of any contract of life insurance or life annuity, the paying of bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that those bonuses or abatement of premiums shall be fair and equitable for policyholders and for the best interests of the company and its policyholders;

(ii) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

(iii) Readjustment of the rate of premium for a group insurance policy based on the loss or expense under the policy at the end of the first or any subsequent policy year of insurance under the policy, which may be made retroactive only for the policy year;

(iv) Engaging in an arrangement that does not violate section 106 of the Bank Holding Company Act Amendments of 1970, 12 U.S.C. § 1972, as interpreted by the Board of Governors of the Federal Reserve System, or section 1464(q) of the Home Owners' Loan Act, 12 U.S.C. § 1461 et seq.; or

(v) Under a prior written agreement with a client paying total annual premiums, for all lines of business, of one hundred thousand dollars (\$100,000) or more, adjusting or refunding a part of a consulting fee charged by a licensed insurance consultant based on commissions received by the consultant from insurance carriers;

(10) "Stock operations and advisory board contracts" means issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock, or other capital stock or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind that promise returns and profits as an inducement to insurance;

(11) "Underwriting: refusing certain risks" means refusing to issue or limiting the amount of coverage on a property or casualty risk based

upon knowledge of an insurer's nonrenewal of the applicant's previous property or casualty policy or contract;

(12) "Unfair claims settlement practices" means committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(G) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

(H) Making claim payments to policyholders or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(I) Delaying the investigation or payment of claims by requiring an insured or claimant, or the physician of either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(J) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts of applicable law for denial of a claim or for the offer of a compromise settlement;

(K) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

(L) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(N) Failing to promptly settle claims, when liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and

(O) Requiring as a condition of payment of a claim that repairs must be made by a particular contractor, supplier, or repair shop;

(13) "Unfair discrimination" means:

(A) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable under the contract of life insurance or of life annuity, or in any other of the terms and conditions of such a contract;

(B) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium policy fees or rates charged for any policy or contract of accident and health insurance, or in the benefits payable under the policy or contract of accident and health insurance, or in any of the terms or conditions of the contract, or in any other manner whatever;

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(i) The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property because of the age of the residential property unless:

(i) The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the marital status of the individual. However, nothing in this subdivision (13)(E) shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage or refusing to issue or refusing to renew any policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subdivision (13)(F) shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(G)(i) Refusing to insure or continue to insure an individual or risks solely because of the individual's race, color, creed, national origin, citizenship, status as a victim of domestic abuse, or sex.

(ii) As used in subdivision (13)(G)(i) of this section, "domestic abuse" means:

(a) Physical harm, bodily injury, or assault between family or household members;

(b) The infliction of fear of imminent physical harm, bodily injury, or assault between family members or household members; or

(c) Sexual conduct between family or household members, whether minors or adults, that constitutes a crime under the laws of this state; and

(H)(i)(a) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of coverage available for life insurance to an individual, or charging an individual a different rate for the same coverage, solely because of the individual's status as a living organ donor.

(b) With respect to other conditions, a person who is a living organ donor shall be subject to the same standards of sound actuarial principles as a person who is not a living organ donor.

(ii) As used in this subdivision (13)(H), "living organ donor" means a person who is a registered organ donor;

(14)(A) "Unfair financial planning practices" includes an insurance producer:

(i)(a) Holding himself or herself out, directly or indirectly, to the public as a financial planner, investment adviser, consultant, financial counselor, or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters, if the insurance producer is, in fact, engaged only in the sale of policies.

(b) However, subdivision (14)(A)(i)(a) of this section does not preclude a person who holds some form of formal recognized financial planning or consultant certification or designation from using the certification or designation when the person is only selling insurance.

(c) Subdivision (14)(A)(i)(a) of this section does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation, or servicing of policies;

(ii)(a) Engaging in the business of financial planning without disclosing in writing to the client, prior to the execution of the agreement provided for in subdivision (14)(A)(iii) of this section, or solicitation of the sale of a product or service that:

(1) He or she is also an insurance salesperson; and

(2) A commission for the sale of an insurance product will be received in addition to a fee for financial planning, if the sale involves a commission.

(b) The disclosure requirement under this subdivision (14)(A)(ii) may be met by including it in any written disclosure required by federal or state securities law; and

(iii)(a)(1) Charging fees other than commissions for financial planning by an insurance producer unless the fees are based upon a written agreement that is signed by the party to be charged in advance of the performance of the services under the agreement.

(2) A copy of the agreement under subdivision (14)(A)(iii)(a)(1) of this section must be provided to the party to be charged at the time the agreement is signed by the party.

(3) The services for which the fee is to be charged must be specifically stated in the agreement.

(4) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(5) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or financial consultant.

(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

(B) "Unfair financial planning practices" does not include funeral expense insurance and prepaid funeral benefits contracts; and

(15)(A) "Unfair property or casualty policy cancellation" means:

(i) After a policy on a property or casualty risk has been in force for more than sixty (60) days or after the effective date of a renewal of the policy, insurance coverage is terminated:

(a) Before the expiration date of the policy for a reason other than provided under subdivision (15)(B) of this section; or

(b) Without providing effective notice as described in subdivision (15)(C) of this section; and

(ii)(a) For a policy in force for sixty (60) days or less, an insurer has terminated the policy without mailing or delivering notice of cancellation to the named insured or to any lienholder or loss payee named in the policy at least twenty (20) days before the effective date of cancellation.

(b) However, when cancellation is for nonpayment of premium, at least ten (10) days' notice of cancellation accompanied by the reason shall be given.

(B) "Unfair property or casualty policy cancellation" does not include an insurer's cancellation of a policy that has been in force for more than sixty (60) days or after the effective date of a renewal of the policy as long as the insurer provides effective notice and terminates the policy for one (1) of the following reasons:

(i) Nonpayment of premium;

(ii) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or presenting a claim under the policy;

(iii) The occurrence of a material change in the risk that substantially increases any hazard insured against after policy issuance;

(iv) Violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy of the property that substantially increases any hazard insured against under the policy;

(v) Nonpayment of membership dues in those cases in which the bylaws, agreements, or other legal instruments of the insurer issuing

the policy require payment as a condition of the issuance and maintenance of the policy; or

(vi) A material violation of a material provision of the policy.

(C)(i) Cancellations of property and casualty policies in force for more than sixty (60) days or after the effective date of a renewal of the policy shall only be effective when notice of cancellation is mailed or delivered by the insurer to the named insured and to any lienholder or loss payee named in the policy at least twenty (20) days before the effective date of cancellation.

(ii) However, when cancellation is for nonpayment of premium, at least ten (10) days' notice of cancellation accompanied by the reason for cancellation shall be given.

(D) This subdivision (15) is not applicable to any policy providing coverage for workers' compensation or employers' liability or to any policy providing coverage for personal automobile liability, automobile physical damage, or automobile collision, or any combination of coverage for personal automobile liability, automobile physical damage, or automobile collision.

History. Acts 1959, No. 148, § 212; 1963, No. 75, § 1; 1973, No. 41, § 2; 1975, No. 729, § 5; 1981, No. 809, §§ 6-9; A.S.A. 1947, § 66-3005; Acts 1987, No. 156, §§ 1, 2; 1987, No. 959, § 20; 1993, No. 1145, § 1; 1995, No. 178, § 1; 1997, No. 1000, § 4; 1999, No. 381, § 1; 2001, No. 1603, §§ 24, 25; 2003, No. 1747, §§ 2, 3; 2009, No. 619, § 1; 2011, No. 797, § 1; 2019, No. 244, § 1; 2019, No. 315, § 2662; 2019, No. 696, § 2; 2021, No. 994, § 1.

Publisher's Notes. For text of section effective July 1, 2022, see the preceding version.

Amendments. The 2019 amendment by No. 244 added (14)(H).

The 2019 amendment by No. 315 substituted "rules" for "regulations" in (4)(B)(vi).

The 2019 amendment by No. 696 substituted "of the complaints received" for

"thereof" in (4)(A); in the introductory language of (4)(B), deleted "since the date of its last examination" following "received" and inserted "for the current year plus five (5) calendar years"; and substituted "As used in" for "For purposes of" in (4)(C).

The 2021 amendment redesignated (4)(B) as (4)(B)(i) and (ii); substituted "The complaints register described in subdivision (4)(B)(i) of this section" for "This complaints register" in (4)(B)(ii); deleted former (9) and redesignated the remaining subdivisions accordingly; substituted "for the life, health, or annuity insurance policy" for "thereon" in (9)(A)(i); added (15); updated internal references; and made stylistic changes.

Effective Dates. Acts 2021, No. 994, § 2: July 1, 2022.

RESEARCH REFERENCES

Ark. L. Rev. Nathan Price Chaney, The Arkansas Deceptive Trade Practices Act: The Arkansas Supreme Court Should

Adopt the Specific-Conduct Rule, 67 Ark. L. Rev. 299 (2014).

23-66-207. Rules to identify prohibited methods of competition, acts, or practices.

(a) The Insurance Commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited

by § 23-66-206 or § 23-66-312, but the rules shall not enlarge upon or extend the provisions of those sections.

(b) The rules shall be subject to review in accordance with § 23-61-307.

History. Acts 1959, No. 148, § 217; 1973, No. 41, § 6; A.S.A. 1947, § 66-3010; Acts 2019, No. 315, § 2663.

Amendments. The 2019 amendment deleted “and regulations” following “Rules” in the section heading; in (a),

deleted “and regulations” following the first occurrence of “rules” and substituted the second occurrence of “rules” for “regulations”; and substituted “rules” for “regulations” in (b).

23-66-214. [Repealed.]

Publisher’s Notes. This section, concerning immunity from prosecution, was repealed by Acts 2017, No. 283, § 13. The

section was derived from Acts 1959, No. 148, § 221; A.S.A. 1947, § 66-3014.

23-66-215. Penalty for late payment of claims by health carriers.

(a)(1) A health carrier shall pay a penalty of twelve percent (12%) per annum for late payment of claims under a health insurance contract pursuant to rules promulgated by the Insurance Commissioner, without necessity for demand for payment by a claimant.

(2) Hiring a third-party administrator or other person to process claims shall not relieve a health carrier of its obligation to pay this penalty.

(b) For purposes of this section:

(1) “Claimant” means a person insured or covered by a health carrier, a provider holding a valid assignment from a person insured or covered by a health carrier, or a provider contracted with a health carrier, who is claiming a benefit under a health insurance contract;

(2)(A) “Health carrier” means a health maintenance organization, hospital medical service corporation, or a disability insurance company.

(B) “Health carrier” includes a self-insured governmental or church plan and third-party administrators that administer or adjust disability benefits for a disability insurer, hospital medical service corporation, health maintenance organization, self-insured governmental plan, or self-insured church plan.

(C) “Health carrier” does not include:

(i) An automobile insurer paying medical or hospital benefits under § 23-89-202(1) or a self-insured employer health benefits plan; or

(ii) Any person, company, or organization licensed or registered to issue or who issues any insurance policy or insurance contract in this state as described in §§ 23-62-102 and 23-62-104 — 23-62-107 providing medical or hospital benefits for accidental injury or disability; and

(3)(A) “Health insurance contract” means a disability insurance policy, a hospital medical service corporation contract, a health

maintenance organization contract, or a plan document issued or provided by a health carrier.

(B) "Health insurance contract" does not include a disability income insurance policy, a long-term care contract, a hospital indemnity contract, an accident-only contract, or any other form of disability insurance policy that provides a benefit as a result of a sickness or accident that does not directly cover expenses related to healthcare treatment.

History. Acts 2001, No. 1454, § 1; substituted "rules" for "regulations" in 2019, No. 315, § 2664.

Amendments. The 2019 amendment

(a)(1).

SUBCHAPTER 3 — MISCELLANEOUS PROHIBITED PRACTICES

SECTION.

23-66-316. Advertising by health and accident insurers and prepaid health plans.

23-66-316. Advertising by health and accident insurers and prepaid health plans.

(a) It shall be unlawful for any insurance company or association transacting any health and accident or hospital or surgical insurance or prepaid hospital and surgical or healthcare plan in this state, in violation of a prior order or rule of the Insurance Commissioner directed to the company or association, to make, issue, circulate, or place before the public or to cause the making, issuing, circulation, or placing before the public in a newspaper, magazine, or other publication or in the form of a notice, brochure, circular, pamphlet, letter, or poster or by way of any radio or television station or in any other way or manner any advertisement, announcement, or statement with respect to the terms, benefits, premiums, or advantages of the policy or plan unless and until the advertisement, announcement, or statement has been filed with and approved by the commissioner, pursuant to the prior order or rule, as not being untrue, deceptive, or misleading in any respect.

(b)(1) Any company or association violating the provisions of this section shall be guilty of a violation and upon a first conviction shall be fined not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) and for a second or subsequent conviction shall be fined not less than five hundred dollars (\$500) nor more than five thousand dollars (\$5,000).

(2) Each violation shall constitute a separate offense.

History. Acts 1965, No. 155, §§ 1, 2; A.S.A. 1947, §§ 66-3027, 66-3028; Acts 2005, No. 1994, § 153; 2019, No. 315, § 2665.

Amendments. The 2019 amendment substituted "rule" for "regulation" twice in (a).

SUBCHAPTER 4 — HOME SERVICE ACT**SECTION.**

23-66-403. Rules.

23-66-404. Required practices.

23-66-403. Rules.

The Insurance Commissioner shall have such authority as he or she deems reasonably necessary to regulate the home service system of distribution, and, to that end, to promulgate, adopt, and enforce reasonable rules necessary and proper to regulate the home service system of distribution.

History. Acts 1993, No. 932, § 3; 1997, No. 749, § 5; 2019, No. 315, § 2666. deleted “and regulations” following “rules” in the section heading and in the text.

Amendments. The 2019 amendment

23-66-404. Required practices.

Each insurer engaged in the home service system of distribution of policies in this state shall:

(1)(A) Establish written procedures to audit agencies engaged in the home service system of distribution of policies in this state;

(B) File the audit procedures in effect each year with the annual statement or provide a certification with each annual statement that the procedures have been adopted;

(C) Conduct audits periodically, or in the manner as described by rules, at the field level or premium payor level which reasonably ensure that the premium payor’s premium recording item or records accurately reflect the premium due date and premium paid-to status of the policy or policies purchased;

(D) Provide a receipt or record to the premium payor reflecting the amount of the premium paid, the date of payment, and the policy number, or other identifying characteristics, toward which the premium is paid if the premium receipt book or other premium recording record is unavailable for marking the premium payments of the payor; and

(E) Provide to a policy owner or premium payor upon request the current paid-to status of any and all policies owned within forty-five (45) days, and, in the event the records of the policy owner or premium payor differ, adjust the company records to credit the policy any previously uncredited payments for which a receipt or other reasonable evidence of payment is submitted by the policy owner; and

(2) With the delivery of the policy, provide notice in bold print with at least 10-point font or size which states:

(A) That a premium savings may be realized by a different or less frequent method of premium payment;

(B) That premiums are still due and payable by the person responsible for premium payments even when an agent does not collect the premiums; and

(C) The mailing address for payment of premiums to the company.

History. Acts 1993, No. 932, § 4; 1997, No. 749, § 2; 2019, No. 315, § 2667. deleted “and regulations” following “rules” in (1)(C).

Amendments. The 2019 amendment

SUBCHAPTER 5 — FRAUDULENT INSURANCE ACTS PREVENTION

SECTION.

23-66-501. Definitions.

23-66-505. Mandatory reporting of fraudulent insurance acts.

23-66-508. Creation and purpose of Criminal Investigation Division.

SECTION.

23-66-511. Rules.

23-66-501. Definitions.

As used in this subchapter:

(1) “Actual malice” means knowledge that information is false, or reckless disregard of whether it is false;

(2) “Business of insurance” means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or are officers, directors, agents, or employees of insurers or who are other persons authorized to act on their behalf;

(3) “Commissioner” means the Insurance Commissioner of this state;

(4) “Fraudulent insurance act” means an act or omission committed by a person who, knowingly and with intent to defraud, deceive, conceal, or misrepresent:

(A) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, a reinsurer, broker or its agent, or by a broker or agent, false information as part of, in support of, or concerning a fact material to one (1) or more of the following:

(i) An application for the issuance or renewal of an insurance policy or reinsurance contract;

(ii) The rating of an insurance policy or reinsurance contract;

(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;

(iv) Premiums paid on an insurance policy or reinsurance contract;

(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract;

(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;

(vii) The financial condition of an insurer or reinsurer;

(viii) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;

(ix) The issuance of written evidence of insurance; or

(x) The reinstatement of an insurance policy;

(B) Solicits or accepts new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(C) Removes, conceals, alters, or destroys the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance;

(D) Embezzles, abstracts, purloins, or converts moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance;

(E) Transacts the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance;

(F) Attempts to commit, aids or abets the commission of, or conspires to commit the acts or omissions specified in this subsection;

(G) Issues false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance;

(H) Possesses or possesses in order to distribute, solicit, sell, negotiate or effectuate false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance to consumers, lienholders or loss payees, insurance agents or producers, or other persons or entities;

(I) Possesses any device, software, or printing supplies utilized to manufacture false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance; or

(J) Falsely holds himself, herself, or itself out as a representative of an insurance company or assists another in furtherance of that misrepresentation to receive a benefit under an insurance claim, contract, or policy;

(5)(A) "Insurance" means a contract or arrangement in which one undertakes to:

(i) Pay or indemnify another as to loss from certain contingencies called "risks", including through reinsurance;

(ii) Pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies;

(iii) Pay an annuity to another; or

(iv) Act as surety.

(B) "Insurance" shall, for the purposes of this subchapter, be deemed to include any definition used in the Arkansas Insurance Code;

(6) "Insurer" means a person entering into arrangements or contracts of insurance or reinsurance and who agrees to perform any of the

acts set forth in subdivision (5)(A) of this section. A person is an insurer regardless of whether the person is acting in violation of laws requiring a certificate of authority or regardless of whether the person denies being an insurer;

(7) "NAIC" means the National Association of Insurance Commissioners;

(8)(A) "Person" means an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing.

(B) "Person" shall, for the purposes of this subchapter, be deemed to include any definition used in the Arkansas Insurance Code;

(9) "Policy" means an individual or group policy, group certificate, contract, or arrangement of insurance or reinsurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state; and

(10) "Reinsurance" means a contract, binder of coverage, including placement slip, or arrangement under which an insurer procures insurance for itself in another insurer as to all or part of an insurance risk of the originating insurer.

History. Acts 1997, No. 217, § 1; 2001, No. 1604, § 45; 2005, No. 1697, § 13; 2013, No. 355, § 10.

23-66-505. Mandatory reporting of fraudulent insurance acts.

(a) A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed shall provide to the Insurance Commissioner the information required by, and in a manner prescribed by, the commissioner.

(b) Any person engaged in the business of insurance who knowingly fails to report as required by subsection (a) of this section shall be guilty of a Class A misdemeanor.

(c) Any other person having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

(d)(1) Upon the request of the commissioner or the commissioner's employees, examiners, investigators, agents, or representatives, a person engaged in the business of insurance shall provide to the commissioner all information the commissioner deems relevant pertaining to any investigation of a fraudulent act or related criminal violation.

(2) The refusal of a person to fully comply with the commissioner's request for information is grounds for the suspension, revocation, denial, or nonrenewal of any license or authority held by the person to engage in an insurance or other business subject to the commissioner's jurisdiction.

(3) A proceeding for the suspension, revocation, denial, or nonrenewal of any license or authority shall be conducted pursuant to §§ 23-63-213 and 23-64-512.

History. Acts 1997, No. 217, § 1; 2005, No. 1697, § 14; 2005, No. 1994, § 230; 2017, No. 283, § 14.

Amendments. The 2017 amendment inserted “or the commissioner’s employees, examiners, investigators, agents, or

representatives” in (d)(1); in (d)(2), substituted “a person” for “any person” and substituted “is grounds” for “shall be grounds”; and, in (d)(3), substituted “A” for “Any” and added “and 23-64-512” at the end.

23-66-508. Creation and purpose of Criminal Investigation Division.

(a)(1) The Criminal Investigation Division is established within the State Insurance Department and is designated a law enforcement agency.

(2)(A) The Insurance Commissioner shall appoint the full-time supervisory and investigative personnel of the division, who shall be qualified by training and experience to perform the duties of their positions.

(B) A person designated and employed as an investigator for the division shall:

(i) Be a certified law enforcement officer under § 12-9-101 et seq.; and

(ii) Have statewide law enforcement jurisdiction and authority.

(3)(A) The commissioner shall designate the personnel assigned to the division who shall conduct investigations under § 23-66-504 and any criminal violations related to those investigations.

(B) Personnel hired as law enforcement officers shall be state-certified in law enforcement or have equivalent national or military law enforcement experience as approved by the Arkansas Commission on Law Enforcement Standards and Training.

(4) The commissioner shall also appoint clerical and other staff necessary for the division to carry out its duties and responsibilities under this subchapter.

(b) It shall be the duty of the division to:

(1) Initiate independent inquiries and conduct independent investigations when the division has cause to believe that a fraudulent insurance act may be, is being, or has been committed;

(2) Review reports or complaints of alleged fraudulent insurance activities from federal, state, and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations; and

(3) Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

(c) The division shall have the authority to:

(1)(A) Issue subpoenas to examine any individual under oath and to compel the production of records, books, papers, contracts, and other documents.

(B) Subpoenas shall be served in the same manner as if issued by a circuit court.

(C) If any individual fails to obey a subpoena issued and served pursuant to this subsection, upon application of the division, the Pulaski County Circuit Court or the circuit court of the county where the subpoena was served may issue an order requiring the individual to comply with the subpoena.

(D) Any failure to obey the order of the court may be punished by the court as contempt thereof;

(2) Administer oaths and affirmations;

(3) Share records and evidence with federal, state, or local law enforcement or regulatory agencies;

(4)(A) Make criminal referrals to prosecuting authorities.

(B) The prosecuting attorney of the judicial district where a criminal referral has been made shall have, for the purpose of assisting in the prosecution, the authority to appoint as special deputy prosecuting attorneys licensed attorneys in the employment of the division.

(C) The prosecuting attorney shall have the right and discretion to proceed against any person or organization on criminal referrals made hereunder, both organizational and individual liability being intended; and

(5)(A) Conduct investigations outside of this state.

(B) If the information the division seeks to obtain is located outside this state, the person from whom the information is sought may make the information available to the division to examine at the place where the information is located.

(C) The division may designate representatives, including officials of the state where the matter is located, to inspect the information on behalf of the division, and the division may respond to similar requests from officials of other states.

History. Acts 1997, No. 217, § 1; 2001, No. 743, § 2; 2005, No. 1697, § 16; 2013, No. 984, § 2; 2015, No. 1164, § 2.

23-66-511. Rules.

The Insurance Commissioner may promulgate reasonable rules deemed necessary by the commissioner for the administration of this subchapter.

History. Acts 1997, No. 217, § 1; 2019, No. 315, § 2668.

Amendments. The 2019 amendment

substituted “Rules” for “Regulations” in the section heading; and deleted “and regulations” following “rules” in the text.

SUBCHAPTER 6 — INSURANCE SALES CONSUMER PROTECTION ACT

SECTION.

23-66-608. Authorization to promulgate rules.

23-66-608. Authorization to promulgate rules.

The Insurance Commissioner may promulgate rules to effectuate the purposes of this subchapter.

History. Acts 1997, No. 900, § 8; 2001, No. 1728, § 3; 2019, No. 315, § 2669. substituted “rules” for “regulations” in the section heading and in the text.

Amendments. The 2019 amendment

CHAPTER 67**RATES AND RATING ORGANIZATIONS**

SUBCHAPTER.

2. REGULATION OF INSURANCE RATES.
3. ARKANSAS WORKERS’ COMPENSATION INSURANCE PLAN.
4. USE OF CREDIT INFORMATION IN PERSONAL INSURANCE ACT.
6. INTERSTATE INSURANCE PRODUCT REGULATION COMPACT.

SUBCHAPTER 2 — REGULATION OF INSURANCE RATES

SECTION.

23-67-214. Licensing of advisory organizations.

SECTION.

23-67-218. Records and reports.
23-67-223. [Repealed.]

23-67-214. Licensing of advisory organizations.

(a) No advisory organization shall provide any service relating to the rates of any insurance subject to this chapter, and no insurer shall utilize the services of the organization for those purposes unless the organization has obtained a license from the Insurance Commissioner.

(b) No advisory organization shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

(c)(1) An advisory organization applying for a license shall include with its application:

(A) A copy of its constitution, charter, or articles of organization, agreement, association, or incorporation and a copy of its bylaws, plan of operation, and any other rules governing the conduct of its business;

(B) A list of its members and subscribers;

(C) The name and address of one (1) or more residents of this state upon whom notices, process affecting it, or orders of the commissioner may be served;

(D) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(E) License fees as provided by § 23-61-401; and

(F) Any other relevant information and documents that the commissioner may require.

(2) Every organization which has applied for a license shall notify the commissioner of every material change in facts or in the documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty (30) days before it becomes effective.

(3) If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed and that all requirements of the law are met, the commissioner shall issue a license specifying the authorized activity of the applicant. The commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to lessen substantially the competition in any market.

(4) Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the state or until the license is suspended or revoked, subject, however, to continuance of the license by the advisory organization each calendar year by:

(A) Payment on or before January 1 of a continuation fee as provided in § 23-61-401;

(B) Due filing of a letter requesting continuation of its license for the following calendar year; and

(C) Submission of information which may be required by the commissioner.

History. Acts 1987, No. 959, § 10; deleted "or regulations" following "rules" 2019, No. 315, § 2670. in (c)(1)(A).

Amendments. The 2019 amendment

23-67-218. Records and reports.

(a) The Insurance Commissioner may adopt reasonable rules for use by companies to record and report to the commissioner rates and other information determined by the commissioner to be necessary or appropriate for the administration of this chapter and for the effectuation of its purposes.

(b)(1) The commissioner may designate an advisory organization to assist the commissioner in gathering, compiling, and reporting the information.

(2) An insurer is not required to record or report its experience on a classification basis inconsistent with its own rating system.

(3) The commissioner may request a review of fire protection standards previously approved if filed by an advisory organization.

History. Acts 1987, No. 959, § 15; 2015, No. 961, § 3.

23-67-223. [Repealed.]

Publisher's Notes. This section, concerning comparison data for private passenger automobile, homeowners multi-peril, and dwelling fire insurance policies,

was repealed by Acts 2017, No. 283, § 15. The section was derived from Acts 2005, No. 1697, § 18.

SUBCHAPTER 3 — ARKANSAS WORKERS' COMPENSATION INSURANCE PLAN

SECTION.

- 23-67-304. Plan for coverage.
- 23-67-306. Employers entitled to insurance.
- 23-67-310. Rules.

SECTION.

- 23-67-311. Association policies.
- 23-67-312. Alternate preferred plan.
- 23-67-313. Competitive selection.

23-67-304. Plan for coverage.

(a) The Arkansas Workers' Compensation Insurance Plan shall give consideration to:

- (1) The need for adequate and readily accessible coverage;
- (2) Optional methods of improving the market affected;
- (3) The need for reasonable underwriting standards;
- (4) The need for adequate supervisory and servicing procedures to ensure proper operation of the plan;
- (5) The need to establish procedures that will have minimum interference with the voluntary market;
- (6) Distributing the obligations imposed by the plan and any profits or losses experienced by the plan equitably and efficiently among the participating insurers; and
- (7) Establishing procedures for applicants and participants to have their grievances reviewed and resolved.

(b)(1) The plan shall provide for the issuance of a policy covering the entire liability of the employer as to the business for which workers' compensation insurance has been rejected.

(2) Nothing in this subsection shall modify or repeal the provisions of § 23-92-409.

(c) The rates and supplementary rate information of the plan shall meet the standards specified in § 23-67-208.

(d) The plan may obtain reinsurance for any part or all of its risks.

(e)(1)(A) At his or her discretion, the Insurance Commissioner is authorized to delegate all or any part of the commissioner's responsibility to establish and operate the plan.

(B) However, any such plan, or plan of operation, and any amendments thereto must receive the prior approval of the commissioner.

(2) Any person or entity to whom the establishment, implementation, or operation of the plan is delegated pursuant to this subsection shall file with and obtain the approval of the commissioner as to all policy forms, rates, or supplementary rate information necessary to effectuate the plan.

(3)(A) In delegating all or part of the commissioner's responsibility, the commissioner shall not approve any plan or filing that abrogates

or restricts his or her authority to select the plan administrator or servicing carriers.

(B) The commissioner shall competitively select the organization or organizations to whom the responsibility of plan administrator shall be delegated.

(C) If the administration of the plan is delegated, the plan administrator or administrators shall have an office in Arkansas adequately staffed, outfitted, and maintained to provide the plan services delegated.

(D) The commissioner shall specify duties and functions of plan administrators and may structure and delegate administrative functions separately such as, but not limited to, rates, forms, and statistics for the best operation of the plan.

(4) Under the provisions of this subsection, the commissioner shall vigorously promote competition for the designation of the plan administrator and servicing carrier for the most effective operation of the plan.

(5)(A) The office in Arkansas is established to improve services provided by the plan, to promote and secure courteous and timely service, and to assure that the minimum standards as provided under subdivision (f)(2) of this section are met.

(B) The office in Arkansas shall also assist employers or agents with questions, problems, or complaints pertaining to the servicing carriers and secure and expedite prompt and fair treatment to employers for servicing carrier errors and service failures.

(6)(A) The Arkansas office manager shall have the authority to intervene with servicing carriers to secure an adequate level of service and prevent servicing carriers from imposing unreasonable demands or actions.

(B) The office manager shall keep a record of all employer or agent problems and complaints by a servicing carrier, including a description of the problem. This record shall be provided to the commissioner within sixty (60) days of each calendar year or upon the request of the commissioner.

(C) The manager shall promptly notify the commissioner of any problems upon a request by an employer.

(f)(1)(A) In order to promote competition and improve servicing carrier performance, the commissioner shall competitively select those servicing carriers who shall serve the plan.

(B) Any insurer licensed to transact workers' compensation and employers' liability insurance in Arkansas may apply for selection as a servicing carrier, but if an adequate number of qualified insurers do not apply, the commissioner may appoint any such insurer, as needed, to serve as a servicing carrier.

(2) All servicing carriers shall be subject to the following minimum standards:

(A) Each insurer shall continually employ such number of qualified administrative personnel and dedicate such equipment and

facilities to the administration of the plan as the commissioner, in his or her reasonable discretion, deems adequate to service the needs of the plan; and

(B) Each such insurer shall comply with the following specific service or performance standards and such further standards as the commissioner may by rule provide:

(i) Provide a level of service comparable to that provided to employer-insureds in its voluntary workers' compensation line of business and assure the same by putting into effect internal administrative procedures, which shall assure that such is the case;

(ii) Maintain with the commissioner a list of responsible management personnel of the insurer qualified to make administrative decisions on the insurer's behalf concerning policies issued within the plan;

(iii) Keep the commissioner continually advised of the address and telephone number of the insurer's office servicing the plan on its behalf;

(iv) Maintain a toll-free telephone number or numbers adequate to service the plan and keep the commissioner, employers, and agents continually apprised of same;

(v)(a) Maintain its billing and rating procedure in timely compliance with orders of the commissioner.

(b) In particular, no insurer shall ever purport to effect a retroactive rate adjustment based upon a succeeding rate filing unless the insurer has specifically included within its policies a specific notice of pending rate change.

(c) No insurer shall fail to physically implement any rate change later than sixty (60) days of the date the order effecting the change is entered;

(vi) Such other service or performance standards, including, but not limited to, matters relating to loss experience, safety and loss control success, and profitability as the commissioner shall by rule prescribe; and

(vii) Such further standards as the commissioner may by rule provide.

(g) The commissioner is vested with the power and the reasonable discretion, after notice and hearing, to impose upon any servicing carrier not meeting the standards herein prescribed or set forth by rule and regulation an administrative fine or penalty in the sum of not more than one thousand dollars (\$1,000) for each such violation of standards. The commissioner shall use this authority to discourage unreasonable or unfair actions by the servicing carriers.

(h) In considering performance of servicing carriers, the commissioner shall require the plan administrator to:

(1) File with the State Insurance Department quarterly results of the plan, including, but not limited to, premiums written and earned, losses paid, incurred losses, and administration and servicing carrier allowances; and

(2) File with the department annually the performance review and plan results of each plan servicing carrier.

(i)(1) Servicing carriers may join cooperatively with other licensed insurers or general business corporations for the purpose of satisfying their duties as servicing carriers, including, but not limited to, claim review and payment, and loss control and safety functions.

(2) The commissioner shall actively encourage additional financially sound licensed carriers or combinations of licensed carriers to join together as joint venturers with shared responsibilities for servicing functions and, also, to utilize the services of such claim, safety, and other service organizations as reasonably necessary to provide the best servicing carrier service economically possible.

(j) The commissioner shall establish within the plan an alternate preferred plan for employers who have carried workers' compensation insurance continually for at least four (4) policy years and who have had better than average loss experience and meet such additional reasonable standards as the commissioner shall by rule prescribe.

(k)(1) The commissioner shall by rule establish a performance plan related to the aforementioned service or performance standards and others to be promulgated with incentives and penalties to improve servicing carrier performance.

(2) The performance plan shall provide for up to thirty-three percent (33%) of the servicing carrier's remuneration to be based on performance.

(3) The servicing carrier performance plan shall provide an annual basis for penalties on carriers performing below standard to the extent of their underperformance under the criteria as hereinafter established by rule up to thirty-three percent (33%) of their remuneration.

(4) These penalties shall be distributed as incentives to carriers performing at or above standard up to thirty-three percent (33%) of their remuneration.

(5)(A)(i) The commissioner shall conduct a comprehensive performance review of the plan administrator as often as the commissioner deems advisable, which shall not be less frequent than one (1) time every five (5) years to the extent necessary for the proper operation of the plan.

(ii) The commissioner shall conduct a performance review of each servicing carrier as often as the commissioner deems advisable in order to assure adequate levels of service.

(B) This comprehensive performance review shall be conducted independently of any other performance review conducted by an organization owned or controlled by the insurance carriers.

(C) A report of this review and action taken to improve plan performance shall be made to the Legislative Council and the House Committee on Insurance and Commerce and the Senate Committee on Insurance and Commerce no later than September 1 after the calendar year reviewed.

History. Acts 1991, No. 561, § 1; 1993, No. 1155, § 1; 1997, No. 1143, § 1; 2001, No. 1721, § 1; 2003, No. 1750, § 7[6]; 2019, No. 315, §§ 2671-2673.

Amendments. The 2019 amendment

deleted “and regulation” following “rule” in the introductory language of (f)(2)(B), in (f)(2)(B)(vi), (f)(2)(B)(vii), (j), (k)(1), and (k)(3).

23-67-306. Employers entitled to insurance.

(a) Any employer required to secure the payment of compensation under the provisions of § 11-9-404(a)(1) or any similar federal law shall be entitled to insurance under the provisions of this subchapter, provided:

(1) The employer pays his or her premium based upon the premium payment rules approved by the Insurance Commissioner;

(2) The employer has complied with all effective laws, orders, or rules, made by public authorities relating to the welfare, health, and safety of employees;

(3) The employer is not in default of premium payments owed for workers' compensation insurance. Provided, however, that no employer shall be deemed to be in default of a premium payment if all of the sum by which he or she is alleged to be in default is properly attributable to a good faith, bona fide dispute between the insurer and the employer over the accuracy or legality of an audit of payroll performed by or at the request of the insurer, and which dispute is in formal process of resolution as provided in § 23-67-219(3). All such disputes shall be resolved in the manner set forth in § 23-67-219(3)(B).

(b) In order to promote competition and improve servicing carrier performance, an employer applying for coverage or on renewal in the Arkansas Workers' Compensation Insurance Plan may strike six (6) servicing carriers, not to exceed a maximum of one-half (½) of the eligible servicing carriers, from the list of eligible servicing carriers to which the employer can be assigned.

History. Acts 1991, No. 561, § 1; 1993, No. 1155, § 2; 2019, No. 315, § 2674.

substituted “or rules” for “rules, or regulations” in (a)(2).

Amendments. The 2019 amendment

23-67-310. Rules.

The Insurance Commissioner is authorized to promulgate such reasonable rules as are necessary to carry out the provisions of this subchapter.

History. Acts 1991, No. 561, § 1; 2019, No. 315, § 2675.

deleted “and regulations” following “rules” in the section heading and in the text.

Amendments. The 2019 amendment

23-67-311. Association policies.

Under such rules as shall be adopted by the Insurance Commissioner, and notwithstanding other provisions of this chapter, the commissioner is given the authority in the Arkansas Workers' Compensation Insur-

ance Plan to allow the issuance of group or association workers' compensation insurance policies to logging contractors or dealers as sponsors. The policies may, in turn, insure for workers' compensation and employers' liability purposes no fewer than five (5) independent contractors who provide logging services to the sponsoring contractor or dealer. Provided, however, that such association or group coverage be made available on a nondiscriminatory basis to all other industries if the commissioner rules that the coverage is reasonably applicable to that industry and economically sound with respect to the plan.

History. Acts 1993, No. 1269, § 1; deleted "and regulations" following "rules" 2019, No. 315, § 2676. near the beginning of the first sentence.

Amendments. The 2019 amendment

23-67-312. Alternate preferred plan.

(a) The Insurance Commissioner shall establish within the Arkansas Workers' Compensation Insurance Plan an alternate preferred plan for employers, including logging or pulpwood dealers or contractors, who have carried workers' compensation insurance coverage continuously for at least four (4) policy years and who have had better than average loss experience and meet such additional reasonable standards as the commissioner shall by rule prescribe.

(b) Such an alternate preferred plan shall address the issues of deductibles and deposit premiums and make such provisions and allowances with respect thereto which are economically sound and in the best interest of the plan and the industries affected.

History. Acts 1993, No. 1269, § 1; deleted "and regulation" following "rule" 2019, No. 315, § 2677. in (a).

Amendments. The 2019 amendment

23-67-313. Competitive selection.

(a) The Insurance Commissioner shall make a good faith effort to comply with the intent of the provisions requiring competitive selection of the administrator of the Arkansas Workers' Compensation Insurance Plan and servicing carriers. The administrator and servicing carriers shall be competitively selected no less often than every three (3) years. Consideration for the administrator and servicing carriers shall include cost, finances, operating and service capabilities, and the record of service and other factors deemed necessary for the effective and proper operation of the plan. The commissioner may suspend formal bidding for the administrator provided that:

(1) The commissioner has sought and compared other administrative services available;

(2) The commissioner deems there to have been in the interim a satisfactory improvement in administrator and servicing carrier performance;

(3) The commissioner judges continuation of the present administrator subject to the modifications herein set forth and to hereafter be promulgated by rule to be in the best interests of Arkansas;

(4) Coverage and service is adequately and properly provided to Arkansas employers entitled to insurance, and coverage is provided in other states for employees of Arkansas employers to the extent possible and the proper coverage is in the best interests of the employers and plan operations. Adequate coverage of employees while working on a temporary or occasional basis in other states is essential to Arkansas employers and employees; and

(5) The administrator has an office in Arkansas and the office has the staff and authority necessary to properly serve Arkansas employers and the commissioner in accordance with the provisions of this act.

(b) The commissioner shall review the plan operations to ensure compliance with this act. The commissioner shall review and report to the Legislative Council and the Senate Committee on Insurance and Commerce and the House Committee on Insurance and Commerce by September 1 of each year, with the first report to be submitted no later than September 1, 1997, including, but not limited to, the following information:

(1) Competitive selection of the administrator and servicing carriers;

(2) Plan operating performance and service in accordance with the intent of this act, including performance reviews of the administrator, servicing carriers, and plan rules;

(3) Proper authority and independence of the Arkansas office to properly perform and secure prompt, fair, and reasonable service as required by this act; and

(4) Coverage provided by the plan in other states, including evidence providing that carriers promptly provide coverage for employees of Arkansas employers working in other states as provided in this act.

(c) The commissioner is encouraged to hold public hearings as needed to assist in achieving the objectives of the act and to assist with the review and report provided to the Legislative Council and the Senate Committee on Insurance and Commerce and the House Committee on Insurance and Commerce.

History. Acts 1993, No. 1155, § 3; deleted “and regulation” following “rule” 1997, No. 1143, § 2; 2019, No. 315, in (a)(3); and substituted “rules” for “regulations” in (b)(2).
§§ 2678, 2679.

Amendments. The 2019 amendment

SUBCHAPTER 4 — USE OF CREDIT INFORMATION IN PERSONAL INSURANCE ACT

SECTION.

23-67-410. Indemnification.
23-67-414. Rules.

SECTION.

23-67-415. [Repealed.]

23-67-410. Indemnification.

(a) An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of a producer who obtains or uses credit information or credit scores, or both, for an insurer, provided the producer follows the instructions of or procedures established by the insurer and complies with any applicable law or rule.

(b) Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

History. Acts 2003, No. 1452, § 2; 2019, No. 315, § 2680.

Amendments. The 2019 amendment substituted “rule” for “regulation” in (a).

23-67-414. Rules.

The Insurance Commissioner may make reasonable rules necessary for or as an aid to the effectuation of any provision of this subchapter.

History. Acts 2003, No. 1452, § 2; 2019, No. 315, § 2681.

substituted “Rules” for “Regulations” in the section heading; and deleted “and regulations” following “rules” in the text.

Amendments. The 2019 amendment

23-67-415. [Repealed.]

Publisher’s Notes. This section, concerning annual reports regarding personal insurance, was repealed by Acts

2017, No. 283, § 16. The section was derived from Acts 2003, No. 1452, § 2.

SUBCHAPTER 6 — INTERSTATE INSURANCE PRODUCT REGULATION COMPACT**SECTION.**

23-67-601. Title.

23-67-602. Adoption of compact.

A.C.R.C. Notes. Acts 2013, No. 1330, § 1, provided: “Purpose — Findings — Effective date.

“(a) The purpose of this act is to join the other states of the United States that have adopted the Interstate Insurance Product Regulation Compact.

“(b) The General Assembly finds that:

“(1) Under Article XIII, Paragraph 2, of the compact:

“(A) The compact becomes effective and binding upon legislative enactment of the compact into law by two (2) states; and

“(B) The Interstate Insurance Product Regulation Commission becomes effective

after adoption of the compact by twenty-six (26) states or by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products;

“(2) Forty (40) states and Puerto Rico have already adopted the compact and represent approximately seventy percent (70%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products nationwide; and

“(3) The State of Arkansas will join the compact on the effective date of this act.”

23-67-601. Title.

This subchapter shall be known and may be cited as the "Interstate Insurance Product Regulation Compact".

History. Acts 2013, No. 1330, § 2.

23-67-602. Adoption of compact.

The Interstate Insurance Product Regulation Compact is enacted into law and entered into with all other jurisdictions legally joining in this compact in the form substantially as follows:

Interstate Insurance Product Regulation Compact

ARTICLE I

PURPOSES

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II

DEFINITIONS

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Non-compacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

ARTICLE III

ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV

POWERS OF THE COMMISSION

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rule-making authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or

mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V

ORGANIZATION OF THE COMMISSION

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to

carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

- i. Establishing the fiscal year of the Commission;
- ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;
- iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;
- iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;
- v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;
- vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;
- vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and
- viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI

MEETINGS AND ACTS OF THE COMMISSION

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

ARTICLE VII

RULES AND OPERATING PROCEDURES: RULEMAKING
FUNCTIONS OF THE COMMISSION AND OPTING OUT OF
UNIFORM STANDARDS

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish

national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition

shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII

COMMISSION RECORDS AND ENFORCEMENT

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a non-complying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission,

the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX

DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

ARTICLE X

PRODUCT FILING AND APPROVAL

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

ARTICLE XI

REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

1. Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third-Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

ARTICLE XII

FINANCE

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third-Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures estab-

lished under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII

COMPACTING STATES, EFFECTIVE DATE, AND AMENDMENT

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

ARTICLE XIV

WITHDRAWAL, DEFAULT, AND TERMINATION

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in

force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

ARTICLE XV

SEVERABILITY AND CONSTRUCTION

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI

BINDING EFFECT OF COMPACT AND OTHER LAWS

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

History. Acts 2013, No. 1330, § 2.

CHAPTER 68

REHABILITATION AND LIQUIDATION OF INSURANCE COMPANIES

SECTION.

23-68-102. Definitions.

23-68-135. Early distribution — Definition.

23-68-102. Definitions.

For the purpose of this chapter:

(1) "Impairment" or "insolvency". The capital of a stock insurer or the surplus of a mutual or reciprocal insurer shall be deemed to be impaired and the insurer shall be deemed to be insolvent when such insurer is not possessed of assets at least equal to all liabilities and required reserves together with its total issued and outstanding capital stock if a stock insurer, or the minimum surplus if a mutual or reciprocal insurer, required by the Arkansas Insurance Code to be maintained for the kind or kinds of insurance it is then authorized to transact.

(2) "Insurer" means any person, firm, corporation, association, or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization or conservation by the commissioner or the equivalent insurance supervisory official of another state.

(3) "Delinquency proceeding" means any proceeding commenced against an insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer.

(4) "State" means any state of the United States and also the District of Columbia and the Commonwealth of Puerto Rico.

(5) "Foreign country" means territory not in any state.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized, or in the case of an insurer incorporated or organized in a foreign country, the state in which such insurer, having become authorized to do business in such state, has, at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States, and any such insurer is deemed to be domiciled in such state.

(7) "Ancillary state" means any state other than a domiciliary state.

(8) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of the Uniform Insurers Liquidation Act, as defined in § 23-68-101, are in force, including the provisions requiring that the commissioner of insurance or equivalent insurance supervisory official be the receiver of a delinquent insurer.

(9) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons, and, as to such specifically encumbered property, the term includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States shall be deemed general assets.

(10) "Preferred claim" means any claim with respect to which the law of the state or of the United States accords priority of payments from the general assets of the insurer.

(11) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any general assets.

(12) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claim or claims against general assets. The term also includes claims which more than four (4) months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(13) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context may require.

(14) "Hazardous financially" means the existence of any condition or the omission or commission of any act which would, in the reasonable discretion of the commissioner, seriously affect the advisability of an insurer's continued operation in this state or, as a result of its financial condition or other matters, would render the insurer's continued operation in this state perilous to the general public or to the policyholders or creditors of the insurer. The commissioner is authorized to

promulgate rules to set forth standards by which he or she might make a determination that the continued operation of an insurer might be hazardous financially.

History. Acts 1959, No. 148, § 638; A.S.A. 1947, § 66-4801; Acts 1993, No. 901, § 33; 2019, No. 315, § 2682.

Amendments. The 2019 amendment substituted “rules” for “regulations” in the last sentence of (14).

23-68-135. Early distribution — Definition.

(a) As used in this section, “distributable asset” means the general assets of an insurer in a liquidation estate except:

(1) Amounts reserved to the extent necessary and appropriate under § 23-68-126(b)(1) as the expenses of the liquidation through and after its closing; and

(2) Amounts reserved to the extent necessary for distribution on claims other than the claims of affected guaranty associations in the priority class of claims under § 23-68-126(b)(2).

(b)(1) An early payment of distributable assets to a guaranty association shall be made:

(A) As frequently as possible after entry of a liquidation order if distributable assets are available, but at least annually; and

(B) In amounts consistent with this section.

(2) An amount distributed to a guaranty association under this section is accounted for as an advance against distributions under § 23-68-126.

(c)(1) Where sufficient distributable assets are available, amounts advanced need not be limited to the claims and expenses paid to date by the guaranty associations.

(2) However, the liquidator shall not distribute distributable assets to the guaranty associations in excess of the anticipated entire claims of the guaranty associations falling within the priority classes of claims established in § 23-68-126(b)(1) and (2).

(d) Within one hundred twenty (120) days after the entry of a liquidation order and at least annually thereafter, the liquidator shall submit to the court:

(1) A financial statement, including:

(A) The assets and liabilities of the insurer;

(B) Any change in the assets and liabilities of the insurer;

(C) The income and expenses of the insurer; and

(D) All funds received or disbursed by the receiver in the liquidation estate during the reporting period;

(2) A report indicating whether or not distributable assets are available based on the financial statement; and

(3)(A) If distributable assets are available, a request for court approval to make early access payments of the distributable assets available to affected guaranty associations out of the general assets of the insurer.

(B) The liquidator may apply to the court to make early access payments more frequently than annually based on additional financial information or the recovery of material assets.

(e) Within sixty (60) days after approval by the court under subdivision (d)(3) of this section, the liquidator shall make early access payments to a guaranty association as indicated in the approved applications.

(f)(1) Notice of each application for early access payments or any report required under this section shall be given to guaranty associations having obligations arising under this section.

(2) At least thirty (30) days before filing a request with the court under subdivision (d)(3) of this section, the liquidator shall provide notice to guaranty associations together with a complete copy of the request.

(3) A guaranty association may:

(A) Request additional information from the liquidator, and the liquidator shall not unreasonably deny the request; and

(B) Object to a request for distribution or any report filed by the liquidator under this section.

(g) In a request for early access payments, the liquidator, at a minimum and based on the information available to the liquidator at the time, shall provide:

(1) The amount reserved for the expenses of the entire liquidation through and after its closure and for distribution on claims in the priority class of claims under § 23-68-126(b)(1) and (2); and

(2) The calculation of distributable assets and the amount and method of equitable allocation of early access payments to guaranty associations.

(h) Each guaranty association that receives any payments pursuant to this section agrees, upon depositing the payment in any account to its benefit, to return to the liquidator any amount of these payments that may be required to pay claims of secured creditors and claims falling within the priority classes of claims established in § 23-68-126(b)(1) and (2).

(i) A bond is not required of any guaranty association under this section.

(j) Without the consent of affected guaranty associations or an order of the court, the liquidator shall not offset the amount to be distributed to a guaranty association by the amount of a special deposit or other deposit or asset of the insurer held in another state unless the guaranty association has received the deposit or asset.

History. Acts 2013, No. 1327, § 1;
2015, No. 1164, § 3.

CHAPTER 69**DOMESTIC STOCK AND MUTUAL INSURERS**

SUBCHAPTER.

1. GENERAL PROVISIONS.
2. STOCK INSURERS — INSIDER TRADING.
3. MUTUAL INSURANCE HOLDING COMPANY ACT.
4. RISK MANAGEMENT AND OWN RISK ASSESSMENT ACT.
5. ARKANSAS INSURANCE BUSINESS TRANSFER ACT.

SUBCHAPTER 1 — GENERAL PROVISIONS

SECTION.

- 23-69-109. Pecuniary interest of officers, directors, employees, etc.
- 23-69-122. Proxies — Stock insurers.
- 23-69-132. Borrowed surplus.
- 23-69-134. Maintenance of home office and records.

SECTION.

- 23-69-144. Agreement or adoption of plan for merger, consolidation, or plan of exchange of shares.
- 23-69-149. Assumption reinsurance — Stock insurers.

23-69-109. Pecuniary interest of officers, directors, employees, etc.

(a) Any officer or director, any member of any committee, or any employee of a domestic insurer who is charged with the duty of investing or handling the insurer's funds:

(1) Shall not deposit or invest the funds except in the insurer's corporate name;

(2) Shall not borrow the funds of the insurer;

(3) Shall not be pecuniarily interested in any loan, pledge of deposit, security, investment, sale, purchase, exchange, reinsurance, or other similar transaction or property of the insurer except as a stockholder or member;

(4) Shall not take or receive to his or her own use any fee, brokerage commission, gift, or other consideration for or on account of any transaction made by or on behalf of the insurer.

(b) No insurer shall guarantee any financial obligation of any of its officers or directors.

(c) This subsection shall not prohibit a director or officer, member of a committee, or employee from becoming a policyholder of the insurer and enjoying the usual rights so provided for its policyholders.

(d) The Insurance Commissioner may, by rule from time to time, define and permit additional exceptions to the prohibition contained in subsection (a) of this section solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer, or to a corporation or firm in which a director is interested, for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private, professional, or business capacity of the director or the corporation or firm.

History. Acts 1959, No. 148, § 488; A.S.A. 1947, § 66-4236; Acts 2019, No. 315, § 2683. **Amendments.** The 2019 amendment substituted “rule” for “regulations” in (d).

23-69-122. Proxies — Stock insurers.

(a) Every proxy of a stockholder of an insurer shall be revocable at will, and this provision cannot be waived.

(b) The revocation of a proxy shall not be effective until notice thereof has been given to the secretary of the insurer.

(c) The Insurance Commissioner shall have the authority to:

(1) Regulate the solicitation of proxies by any person;

(2) Require the disclosure of information deemed relevant to an understanding of issues and matters with respect to which proxies are, or are proposed to be, solicited;

(3) Specify general requirements as to form and contents of proxies;

(4) Determine the length of time for which proxies may be effective unless sooner revoked;

(5) Prohibit solicitations of proxies which do not comply with such rules as the commissioner may issue hereunder, or as to which disclosures required by the rules are not made;

(6) Prohibit the making or use of false or misleading statements or the distribution of any false or misleading material with respect to the solicitation of any proxy or with respect to any election or election contest; and

(7) Issue such other rules respecting proxies and elections as the commissioner may deem necessary or appropriate in the public interest or for the protection of stockholders of insurers.

(d) Rules issued by the commissioner under authority of this section shall be made or amended as provided in § 23-61-108.

(e) Insofar as may be practical, rules and regulations with respect to proxies, consents, or authorizations then currently approved or formulated by the National Association of Insurance Commissioners, or its successor organization, shall be followed.

History. Acts 1959, No. 148, § 472; 1965, No. 459, § 1; A.S.A. 1947, § 66-4220; Acts 2019, No. 315, § 2684. **Amendments.** The 2019 amendment deleted “and regulations” following “rules” in (c)(5) twice, in (c)(7), and in (d).

23-69-132. Borrowed surplus.

(a)(1)(A) A domestic stock or mutual insurer may borrow cash or other admitted assets satisfactory to the Insurance Commissioner to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon entering a written agreement that the cash or other admitted assets are required to be repaid only out of the insurer’s surplus in excess of that stipulated in the agreement.

(B) The agreement described in subdivision (a)(1)(A) of this section may provide for interest which shall or shall not constitute a liability

of the insurer as to its funds other than the excess or surplus, as stipulated in the agreement.

(2) A commission or promotion expense shall not be paid in connection with the loan.

(b)(1) Cash or other admitted assets satisfactory to the commissioner borrowed under subsection (a) of this section, together with the interest thereon, if stipulated to in the agreement, shall not be:

(A) Included in the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated to in the agreement; or

(B) The basis of any setoff.

(2) Until the cash or other admitted assets are repaid, the financial statements filed or published by the insurer shall show as a footnote thereto the amount of surplus borrowed, any remaining balance, and any accrued interest unpaid.

(c)(1) Any loan to an insurer shall be subject to the Insurance Commissioner's approval.

(2) The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement.

(3) The loan and agreement shall be deemed approved unless, within fifteen (15) days after the date of filing, the insurer is notified of the commissioner's disapproval and the reasons therefor.

(4) The commissioner shall disapprove any proposed loan or agreement if he or she finds the loan is unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

(d) Any loan to an insurer or substantial portion thereof shall be repaid by the insurer when no longer necessary for the purpose originally intended. No repayment of the loan shall be made by an insurer unless it is approved by the commissioner in advance.

(e) This section shall not apply to loans obtained by the insurer in the ordinary course of business from banks and other financial institutions nor to loans secured by pledge or mortgage of assets.

History. Acts 1959, No. 148, § 485; A.S.A. 1947, § 66-4233; Acts 2001, No. 1604, § 54; 2015, No. 1223, §§ 29, 30.

23-69-134. Maintenance of home office and records.

(a) Every domestic insurer shall have and maintain its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind or kinds of insurance transacted.

(b) Every domestic insurer shall have and maintain its assets in this state, except as to:

(1) Real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state;

(2) Such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (d) of this section;

(3) Such securities of the insurer that are readily marketable and have a maturity of one (1) year or less from the date of purchase and that are kept in safekeeping in a federally chartered bank, bank and trust company, or national bank association domiciled outside the State of Arkansas, provided that:

(A) The insurer shall maintain in its possession a safekeeping receipt for those securities evidencing uncontested ownership; and

(B) At no time shall the insurer hold pursuant to this subdivision (b)(3) securities in an aggregate amount in excess of the greater of:

(i) Ten percent (10%) of its assets; or

(ii) Forty percent (40%) of its surplus if a life or accident and health insurer or of its surplus to policyholders if other than a life or accident and health insurer; and

(4) In the discretion of the Insurance Commissioner, custodied securities may be held or managed inside or outside the state by a bank custodian as defined by and subject to the requirements imposed on bank custodians by rules of the State Insurance Department governing the holding and transferring of securities through a clearing corporation. In addition, custodied securities may be held or managed inside or outside the state by a securities brokerage firm meeting the following qualifications:

(A) The securities broker-dealer firm must be registered with and subject to jurisdiction of the United States Securities and Exchange Commission, maintain membership in the Securities Investor Protection Corporation, and demonstrate by its most recent audited financial statement and regulatory filings:

(i) Tangible net worth that satisfies the capital and financial requirements of a custodian as defined by rules promulgated by the department and regulatory net capital in an amount determined by the commissioner; or

(ii) Tangible net worth that satisfies the capital and financial requirements of a custodian as defined by rules promulgated by the department along with:

(a) Regulatory net capital in an amount determined by the commissioner; and

(b) Securities Investor Protection Corporation excess insurance coverage equal to or greater than the market value of the insurers' securities held by the custodian and in the form approved by the commissioner;

(B) The deposited securities with the qualified broker-dealer must be governed by a written custodial agreement governing the insurer's deposit of the insurer's securities such that the qualified broker-dealer agrees that:

(i) The qualified broker-dealer shall exercise the same due care that is expected of a fiduciary with the responsibility for the safeguarding of the insurer's custodied securities and for compliance with all provisions of the custodial agreement, whether the insurer's custodied securities are in the custodian's possession or have been deposited or redeposited by the custodian with a subcustodian;

(ii) The qualified broker-dealer shall indemnify the insurer for any loss of custodied securities occasioned by the negligence or dishonesty of the custodian's officers and employees or burglary, robbery, hold-up, theft, or mysterious disappearance, including loss by damage or destruction. In the event of such a loss, the custodian must promptly replace the custodied securities or the value thereof and the value of any loss of rights or privileges resulting from the loss of custodied securities;

(iii) Custodied securities shall be segregated at all times from the proprietary assets of the broker-dealer. The broker-dealer's official records shall separately identify custodied securities owned by the insurer;

(iv) All custodied securities that are registered shall be registered in the name of the insurer or in the name of a nominee of the insurer or in the name of the custodian or its nominee or, if in a depository corporation, in the name of the depository corporation or its nominee;

(v) All activities involving the insurer's custodied securities shall be subject to the insurer's instructions, and the custodied securities shall be withdrawable upon demand by the insurer or by the commissioner at any time;

(vi) The custodian shall furnish upon request by the insurer or by the commissioner a confirmation of all purchases, sales, or transfers of custodied securities to or from the account of the insurer, reports of custodied securities sufficient to verify information reported in the insurer's annual statement filed with the department, and supporting schedules and information required in any audit of the insurer's financial statement;

(vii) The insurer or its designee or the commissioner shall at all times be entitled to examine all records maintained by the broker-dealer relating to the insurer's custodied securities;

(viii) The custodian shall not use any of the insurer's custodied securities for the broker-dealer's benefit, and none of the insurer's custodied securities shall be loaned, pledged, or hypothecated to any person or organization;

(ix) The broker-dealer shall maintain securities all risks coverage or other insurance satisfactory to the commissioner at levels considered reasonable and customary for the custodian banking industry covering the broker-dealer's duties and activities as custodian for the insurer's assets and shall describe the nature and extent of the insurance protection. Any change in the insurance protection during the term of the custodial agreement shall be promptly disclosed to the insurer;

(x) The broker-dealer is authorized and instructed by the insurer to honor any requests made by the department for information concerning the insurer's custodied securities. The department, from time to time, may request and the custodian shall furnish a detailed listing of the insurer's custodied securities and an affidavit by the broker-dealer certifying the custodian's safekeeping responsibilities relative to the custodied securities. The broker-dealer's response to such requests shall be made directly to the department and shall encompass all of the insurer's custodied securities; and

(xi) Any other requirements provided by rules of the commissioner; and

(5)(A) Government money market mutual fund or class one money market mutual fund shares held or managed by a securities broker-dealer firm which meets the standards prescribed in subdivision (b)(4)(A) of this section, subject to any limitations on domestic insurer investments of this nature which may be otherwise contained in the Arkansas Insurance Code. Provided further that no such money market mutual fund shares owned by the insurer shall be required to be issued in certificated form, nor held by the insurer in a custodian account.

(B) For purposes of this subsection:

(i) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment using the bond class one reserve factor under the "Purposes and Procedures Manual of the NAIC Securities Valuation Office" or any successor publication;

(ii) "Government money market mutual fund" means a money market mutual fund that at all times:

(a) Invests only in obligations issued, guaranteed, or insured by the United States Government or collateralized repurchase agreements composed of these obligations; and

(b) Qualifies for investment without a reserve under the Purposes and Procedures of the Securities Valuation Office of the National Association of Insurance Commissioners or any successor publication;

(iii) "Money market mutual fund" means a mutual fund that meets the conditions of 17 C.F.R. Part 270.2a-7, under the Investment Company Act of 1940, 15 U.S.C. §§ 80a-1 et seq., as amended or renumbered; and

(iv) "Mutual fund" means an investment company or, in the case of an investment company that is organized as a series company, an investment company series that, in either case, is registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940, 15 U.S.C. §§ 80a-1 et seq., as amended.

(c)(1) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or consolidation approved by the commissioner under the Arkansas Insurance Code, or for such other reasonable purposes and periods of time as

may be approved by the commissioner in writing in advance of the removal or concealment of the records or assets or material part thereof from the commissioner is prohibited.

(2) Any person who removes or attempts to remove the records or assets or the material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the purpose of removing them from this state or who conceals or attempts to conceal them from the commissioner, in violation of this subsection, shall be guilty of a Class D felony.

(3) Upon any removal or attempted removal of the records or assets, or upon retention of the records or assets or material part thereof outside this state beyond the period specified in the commissioner's consent under which the records were so removed, or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of § 23-68-101 et seq.

(d) This section shall not be deemed to prohibit or prevent an insurer from:

(1) Establishing and maintaining branch offices or regional home offices in other states when necessary or convenient to the transaction of its business and keeping in those offices the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by the office, as long as the records and assets are made readily available at the office for examination by the commissioner at his or her request;

(2) Having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside this state as reasonably and customarily required in the regular course of its business; or

(3) Maintaining its home office, records, and assets in another state, provided:

(A) The insurer shall keep in its home office complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kinds of insurance transacted;

(B) The insurer was maintaining its home office in another state upon January 1, 1960;

(C) All records and assets of the insurer are made readily available at the home office for examination by the commissioner at his or her request; and

(D) The insurer shall maintain a principal place of business in this state where service of process may be made as provided in §§ 23-79-204 and 23-79-205.

History. Acts 1959, No. 148, § 489; A.S.A. 1947, § 66-4237; Acts 1989, No. 772, § 12; 1999, No. 452, § 1; 2001, No. 1603, § 29; 2001, No. 1604, §§ 55, 56; 2005, No. 1994, § 451; 2007, No. 496, §§ 13, 14; 2019, No. 315, § 2685.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (b)(4)(B)(xi).

23-69-144. Agreement or adoption of plan for merger, consolidation, or plan of exchange of shares.

(a) The directors, or a majority of them, of the corporations as desire to merge or consolidate or adopt a plan of exchange of shares pursuant to § 23-69-142 or § 23-69-143 shall enter into an agreement or adopt a plan signed by them and under the corporate seals of the respective corporations prescribing the terms and conditions of the merger or consolidation or plan of exchange of shares, the mode of carrying the same into effect, provisions with respect to abandonment, the effective date of the proposal or method of determination thereof and stating such other facts as are deemed applicable among those necessary to be set out in articles of incorporation, as provided in § 23-69-105, as well as the manner and basis of any issuance, conversion, or exchange of shares of stock involved in the proposal, and with such other details and provisions as are deemed necessary or desirable.

(b)(1) The agreement of merger or consolidation shall be submitted to the stockholders, in the case of a stock insurer, or members, in the case of a mutual insurer, of each corporation at meetings thereof and called for the purpose of taking it into consideration. A plan of exchange of shares shall be submitted to the stockholders of the insurer to be acquired at a meeting thereof called for that purpose.

(2) Notice shall be given of the time, place, and object of the meeting to each stockholder or member of record, whether entitled to vote or not.

(3) At the meeting, the agreement or plan shall be considered and a vote by ballot, in person or by proxy, shall be taken for the adoption or rejection of the agreement or plan.

(4) If the votes of stockholders, in the case of a stock insurer, holding stock of the corporation entitling them to exercise at least a majority of the voting power, or such other proportion of the stockholders as may be prescribed in the corporation's articles of incorporation for votes on such a proposal, or, in the case of a mutual insurer, the votes of the number or proportion of members of the insurer as required under § 23-69-143(b), shall be for the adoption of the agreement or plan, then that fact shall be certified in the agreement or plan by the secretary or assistant secretary of each corporation, under the seal thereof.

(5) The agreement or plan so adopted and certified shall be signed by each constituent corporation under its seal and the hands of its president or a vice president and its secretary or an assistant secretary and acknowledged before an officer authorized by the laws of Arkansas to take acknowledgment of deeds.

(c)(1) The agreement or plan, adopted and certified as provided in subsections (a) and (b) of this section, shall be filed in duplicate originals with the Insurance Commissioner, and thence shall be taken and deemed to be the agreement and act of merger or consolidation or plan of exchange of shares of the constituent corporations, and, in the case of a consolidation, as the certificate of incorporation of the consolidated corporations.

(2) A copy of the agreement or plan certified by the commissioner shall be evidence of the performance of all antecedent acts and conditions necessary to the merger and consolidation or plan of exchange of shares and of the existence of the consolidated corporation.

(3) [Repealed.]

(d) Any agreement of merger or consolidation or plan of exchange may be abandoned in conformity with the terms thereof as approved by the commissioner. However, in such event, due notice of the abandonment shall be immediately transmitted to the stockholders or members of all domestic insurance corporations which are parties thereto within ten (10) days of the abandonment in a manner and form as prescribed or approved by the commissioner. With regard to proposed affiliations between a depository institution, or any affiliate thereof, and an insurer, the hearing may be cancelled and the matter concluded and the notice of abandonment issued within the period required by federal law.

History. Acts 1971, No. 301, § 3; A.S.A. 1947, § 66-4247; Acts 2001, No. 1604, § 64; 2021, No. 367, § 16. **Amendments.** The 2021 amendment repealed (c)(3).

23-69-149. Assumption reinsurance — Stock insurers.

(a)(1) A domestic stock insurer may reinsure all or substantially all of its insurance in force or a major class thereof with another insurer by an agreement of assumption reinsurance.

(2) However, an agreement shall not become effective unless filed with the Insurance Commissioner and approved by him or her in writing.

(3) With regard to proposed transactions between a domestic stock insurer which is a subsidiary or affiliate of a depository institution, and another insurer, the determination of the commissioner shall be issued within the period required by federal law.

(b) The commissioner shall approve the agreement within a reasonable time after the filing unless he or she finds that it is inequitable to the stockholders of the domestic insurer or would substantially reduce the protection or service to its policyholders. If the commissioner does not approve the agreement, he or she shall so notify the insurer in writing specifying his or her reasons therefor.

History. Acts 1959, No. 148, § 502; A.S.A. 1947, § 66-4250; Acts 2001, No. 1604, § 66; 2019, No. 521, § 20.

Amendments. The 2019 amendment added the (a)(1) through (a)(3) designations; in (a)(2), substituted “an agreement shall not become” for “no agreement shall

become” and deleted “after a hearing thereon” following “writing”; and, in (a)(3), substituted “determination of the commissioner shall be issued” for “hearing shall be concluded and the order issued” and deleted “and the order shall be final upon entry” following “law”.

SUBCHAPTER 2 — STOCK INSURERS — INSIDER TRADING**SECTION.**

23-69-201. Definition.

23-69-203. Application of §§ 23-69-204 — 23-69-206 to foreign or domestic arbitrage transactions.

23-69-205. Prevention of unfair use of information by owners, directors, or officers.

SECTION.

23-69-207. Equity securities held in an investment account.

23-69-208. Rules.

23-69-201. Definition.

As used in this subchapter, unless the context otherwise requires, “equity security” means:

- (1) Any stock or similar security;
- (2) Any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security;
- (3) Any such warrant or right; or
- (4) Any other security which the Insurance Commissioner shall deem to be of similar nature and consider necessary or appropriate, by such rules as he or she may prescribe in the public interest or for the protection of investors, to treat as an equity security.

History. Acts 1965, No. 107, § 6; A.S.A. 1947, § 66-4263; Acts 2019, No. 315, § 2686.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in (4).

23-69-203. Application of §§ 23-69-204 — 23-69-206 to foreign or domestic arbitrage transactions.

The provisions of §§ 23-69-204 — 23-69-206 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules as the Insurance Commissioner may adopt in order to carry out the purposes of this subchapter.

History. Acts 1965, No. 107, § 5; A.S.A. 1947, § 66-4262; Acts 2019, No. 315, § 2687.

Amendments. The 2019 amendment deleted “and regulations” following “rules”.

23-69-205. Prevention of unfair use of information by owners, directors, or officers.

(a) For the purpose of preventing the unfair use of information which may have been obtained by a beneficial owner of more than ten percent (10%) of any class of any equity security, director, or officer by reason of his or her relationship to the company, any profit realized by him or her from any purchase and sale, or any sale and purchase, of any equity security of the company within any period of less than six (6) months, unless the security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company,

irrespective of any intention on the part of the beneficial owner, director, or officer in entering into the transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six (6) months.

(b) Suit to receive the profit may be instituted in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring the suit within sixty (60) days after request or shall fail to prosecute diligently the suit thereafter. However, no suit shall be brought more than two (2) years after the date the profit was realized.

(c) This section shall not be construed to cover any transaction where the beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the Insurance Commissioner by rules may exempt as not comprehended within the purpose of this section.

History. Acts 1965, No. 107, § 2; A.S.A. 1947, § 66-4259; Acts 2019, No. 315, § 2688.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in (c).

RESEARCH REFERENCES

ALR. Application of Holding in <i>Dirks v. S.E.C.</i> , 463 U.S. 646 (1983), That Recipient of Tip From Insider Must Abstain	From Using Such Information If Insider Will Benefit From Disclosing Tip. 42 A.L.R. Fed. 3d Art. 8 (2019).
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23-69-206. Restrictions on sale of equity securities.

RESEARCH REFERENCES

ALR. Application of Holding in <i>Dirks v. S.E.C.</i> , 463 U.S. 646 (1983), That Recipient of Tip From Insider Must Abstain	From Using Such Information If Insider Will Benefit From Disclosing Tip. 42 A.L.R. Fed. 3d Art. 8 (2019).
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23-69-207. Equity securities held in an investment account.

(a) The provisions of § 23-69-205 shall not apply to any purchase and sale, or sale and purchase, and the provisions of § 23-69-206 shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him or her in an investment account, by a dealer in the ordinary course of his or her business and incident to the establishment or maintenance by him or her of a primary or secondary market, otherwise than on an exchange as defined in the Securities Exchange Act of 1934 for such a security.

(b) The Insurance Commissioner may, by such rules as he or she deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

History. Acts 1965, No. 107, § 4; A.S.A. 1947, § 66-4261; Acts 2019, No. 315, § 2689.

Amendments. The 2019 amendment deleted “and regulations” following “rules” in (b).

23-69-208. Rules.

(a) The Insurance Commissioner shall have the power to make such rules as may be necessary for the execution of the functions vested in him or her by this subchapter and for such purpose may classify domestic stock insurance companies, securities, and other persons or matters within his or her jurisdiction.

(b) No provision of this subchapter imposing any liability shall apply to any act done or omitted, in good faith, in conformity with any rule of the commissioner, notwithstanding that the rule, after the act or omission, may be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

History. Acts 1965, No. 107, § 8; A.S.A. 1947, § 66-4265; Acts 2019, No. 315, § 2690.

deleted “and regulations” following “rules” in the section heading and in (a); and deleted “or regulation” following “rule”

Amendments. The 2019 amendment twice in (b).

SUBCHAPTER 3 — MUTUAL INSURANCE HOLDING COMPANY ACT

SECTION.

23-69-321. Injunctive orders.

23-69-322. Promulgation of rules.

23-69-321. Injunctive orders.

Whenever it appears to the Insurance Commissioner that any person or any director, officer, employee, or agent of the person has committed or is about to commit a violation of this subchapter or of any rule or order of the commissioner, the commissioner may apply to the Pulaski County Circuit Court for an order enjoining such person, director, officer, employee, or agent from violating or continuing to violate this subchapter or any such rule or order and for such other equitable relief as the nature of the case and the interest of the insurer’s policyholders, creditors, and shareholders or the public may require.

History. Acts 2001, No. 1726, § 1; 2019, No. 315, § 2691.

deleted “regulation” following “rule” twice.

Amendments. The 2019 amendment

23-69-322. Promulgation of rules.

The Insurance Commissioner may adopt and promulgate rules and issue orders to carry out this subchapter.

History. Acts 2001, No. 1726, § 1; 2019, No. 315, § 2692.

deleted “and regulations” following “rules” in the section heading and in the text.

Amendments. The 2019 amendment

SUBCHAPTER 4 — RISK MANAGEMENT AND OWN RISK ASSESSMENT ACT

SECTION.

- 23-69-401. Title.
- 23-69-402. Findings and intent.
- 23-69-403. Definitions.
- 23-69-404. Risk management framework.
- 23-69-405. Own risk and solvency assessment — Requirements.
- 23-69-406. Own risk and solvency assessment summary.

SECTION.

- 23-69-407. Exemption — Applicability.
- 23-69-408. Own risk and solvency assessment summary report — Content.
- 23-69-409. Confidentiality.
- 23-69-410. Sanctions.

23-69-401. Title.

This subchapter shall be known and may be cited as the “Risk Management and Own Risk Assessment Act”.

History. Acts 2015, No. 1223, § 31.

23-69-402. Findings and intent.

(a) The General Assembly finds that:

(1) The Insurance Commissioner requires an insurer or insurance group to submit confidential and privileged information to the State Insurance Department to allow the commissioner to evaluate the financial condition and stability of the insurer or insurance group to protect the public;

(2) An insurer or insurance group may be reluctant to provide this information to the commissioner due to the sensitive nature of the information that is specific to the insurer or insurance group’s identification of risks material, including proprietary and trade secrets of the insurer or insurance group filing the report; and

(3) The information required by the commissioner to evaluate the financial stability of an insurer or insurance group if disclosed to the public has the potential to cause harm to an insurer or insurance group.

(b) It is the intent of the General Assembly to ensure that:

(1) A method is established to clarify the requirements for an insurer or insurance group to maintain a risk management framework;

(2) An insurer or insurance group is able to share its own risk and solvency assessment with the commissioner to enable the commissioner to assess the financial stability of an insurer or insurance group to meet policyholder obligations;

(3) An insurer or insurance group’s own risk assessment summary report remains confidential if filed with the commissioner, subject to the rules adopted by the commissioner, and shall not be published, made publically available, or subject to public disclosure; and

(4) The commissioner may only share an insurer or insurance group’s own risk assessment summary report as stated in this subchapter and as necessary to assist the commissioner in performing his or her duties.

History. Acts 2015, No. 1223, § 31.

23-69-403. Definitions.

As used in this subchapter:

(1) "Insurance group" means an insurer and the insurer's affiliates that are in an insurance holding company system, as defined in the Insurance Holding Company Regulatory Act, § 23-63-501 et seq.;

(2) "Insurer" means the same as defined in § 23-62-402, except "insurer" does not include an agency, authority, commission, or other instrumentality of the United States or any state or territory of the United States;

(3) "Own risk and solvency assessment" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer's or insurance group's current business plan and the sufficiency of capital resources to support those risks;

(4)(A) "Own Risk and Solvency Assessment Guidance Manual" means the guidance manual developed and adopted by the National Association of Insurance Commissioners.

(B) A revision made by the National Association of Insurance Commissioners to the Own Risk and Solvency Assessment Guidance Manual shall be implemented on January 1 following the calendar year that the revision is adopted by the National Association of Insurance Commissioners; and

(5) "Own risk and solvency assessment summary report" means a confidential and proprietary summary of an insurer's or insurance group's own risk and solvency assessment.

History. Acts 2015, No. 1223, § 31.

23-69-404. Risk management framework.

(a) An insurer shall establish and maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on the insurer's material and relevant risks.

(b) An insurer may satisfy subsection (a) of this section if the insurance group that the insurer is a member of maintains a risk management framework that is applicable to the operations of the insurer.

History. Acts 2015, No. 1223, § 31.

23-69-405. Own risk and solvency assessment — Requirements.

Except as provided in § 23-69-407, an insurer or the insurance group that the insurer is a member of shall perform an own risk and solvency assessment:

(1) According to the Own Risk and Solvency Assessment Guidance Manual or a comparable process; and

(2) Annually, or at any time a significant change to the risk profile of the insurer or the insurance group of which the insurer is a member occurs.

History. Acts 2015, No. 1223, § 31.

23-69-406. Own risk and solvency assessment summary.

(a)(1)(A) Upon request, an insurer shall submit to the Insurance Commissioner no more than one (1) time a year beginning January 1, 2017, an own risk and solvency assessment summary report, or any combination of filings applicable to the insurer or the insurance group of which the insurer is a member, that together contain the information described in the Own Risk and Solvency Assessment Guidance Manual.

(B) An insurer may submit a comparable report that provides the most recent and substantially similar information under subdivision (a)(1)(A) of this section to a commissioner in another state or to the supervisor or regulator of a foreign jurisdiction provided by the insurer or another member of an insurance group of which the insurer is a member.

(2) Notwithstanding a request from the Insurance Commissioner, an insurer that is a member of an insurance group shall submit the reports required under subdivision (a)(1) of this section if the Insurance Commissioner is the lead state commissioner of the insurance group as determined by the procedures within the "Financial Analysis Handbook" adopted by the National Association of Insurance Commissioners.

(b) A report described in subdivision (a)(1)(A) of this section shall include an attestation of the chief risk officer or other executive of the insurer or insurance group that is responsible for the oversight of the insurer's enterprise risk management process that to the best of his or her belief and knowledge:

(1) The insurer applies the enterprise risk management process described in the insurer's own risk and solvency assessment summary report; and

(2) A copy of the report has been provided to the insurer's board of directors or other governing body of the insurer.

(c) A report under subdivision (a)(1) of this section shall be in English or translated to English before filing with the Insurance Commissioner.

History. Acts 2015, No. 1223, § 31.

23-69-407. Exemption — Applicability.

(a) An insurer is exempt from this subchapter if:

(1) The insurer has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums, but excluding premiums reinsured with the Federal Crop Insurance Cor-

poration and National Flood Insurance Program, of less than five hundred million dollars (\$500,000,000); and

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums, but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, of less than one billion dollars (\$1,000,000,000).

(b)(1) If an insurer qualifies for an exemption under subdivision (a)(1) of this section and the insurance group of which the insurer is a member does not qualify for an exemption under subdivision (a)(2) of this section, then an own risk and solvency assessment summary report required under § 23-69-406 shall include every insurer that is a member of the insurance group.

(2) In order to meet the requirement under subdivision (b)(1) of this section, an insurer may submit more than one (1) own risk and solvency assessment summary report for any combination of insurers if any combination of own risk and solvency assessment summary reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for an exemption under subdivision (a)(1) of this section and the insurance group of which the insurer is a member does qualify for an exemption under subdivision (a)(2) of this section, then only an own risk and solvency assessment summary report applicable to the insurer is required under § 23-69-406.

(d)(1) An insurer that does not qualify for an exemption under subdivision (a)(1) of this section may request a waiver from the commissioner of the reporting requirements under this subchapter due to unique circumstances.

(2) In determining whether to grant a waiver to an insurer under subdivision (d)(1) of this section, the commissioner may:

(A) Consider the insurer's type and volume of business written, ownership and organizational structure, and any other factors the commissioner considers relevant to the insurer or insurance group of which the insurer is a member; or

(B) Coordinate with the insurance group's lead state commissioner and other domiciliary commissioners if the insurer is a member of an insurance group with insurers domiciled in more than one (1) state, to determine whether or not to grant the insurer's waiver request.

(e) Notwithstanding an exemption under this section, the commissioner may require that an insurer:

(1) Maintain a risk management framework, conduct an own risk and solvency assessment, and file an own risk and solvency assessment summary report based on an insurer's unique circumstances, including without limitation the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; or

(2) Maintain a risk management framework, conduct an own risk and solvency assessment, and file an own risk and solvency assessment summary report if the insurer:

(A) Has risk-based capital for a company action level event under § 23-63-1304 or § 23-63-1503; or

(B) Meets at least one (1) of the standards of an insurer deemed to be in a hazardous financial condition, as defined in State Insurance Department Rule 53, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(f) If an insurer has qualified for an exemption under subsection (a) of this section and subsequently no longer qualifies for that exemption due to changes in premiums as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, then the insurer shall have one (1) year following the year the threshold is exceeded to comply with this subchapter.

(g) A domiciled insurer shall be subject to this subchapter unless the insurer is exempt under this section.

History. Acts 2015, No. 1223, § 31.

23-69-408. Own risk and solvency assessment summary report — Content.

(a)(1) An own risk and solvency assessment summary report shall be prepared pursuant to the Own Risk and Solvency Assessment Guidance Manual, subject to the requirements of subsection (b) of this section.

(2) An insurer shall maintain any documentation and supporting information used to prepare an own risk and solvency assessment summary report and make the documents and information available upon request of the Insurance Commissioner or during an examination.

(b) An own risk and solvency assessment summary report and any additional requests for information shall be reviewed under similar procedures currently in use during an analysis and examination of multistate or global insurers and insurance groups.

History. Acts 2015, No. 1223, § 31.

23-69-409. Confidentiality.

(a) Any documents, materials, or other information, including an own risk and solvency assessment summary report, in the possession of or under the control of the State Insurance Department that are obtained by, created by, or disclosed to the Insurance Commissioner or any other person under this subchapter is recognized as being proprietary and containing trade secrets.

(b)(1) Any documents, materials, or other information submitted under this subchapter shall be confidential by law and privileged.

(2) The information required under this subchapter is not subject to:

(A) The Freedom of Information Act of 1967, § 25-19-101 et seq.;

(B) Subpoena; or

(C) Discovery or admissible in evidence in any private civil action.

(c)(1) Notwithstanding the limitations under this section, the commissioner may use the documents, materials, or other information to further any regulatory or legal action brought on behalf of the commissioner.

(2) The commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(d) The commissioner or any person operating on behalf of the commissioner shall not be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information under this subchapter.

(e) In order to assist in the performance of the regulatory duties of the commissioner, upon request, the commissioner:

(1) If the recipient agrees in writing to maintain the confidentiality and privileged status of the own risk and solvency assessment documents, materials, or other information and verifies in writing the legal authority to maintain confidentiality, may share:

(A) Documents, materials, or other information of an own risk and solvency assessment, including confidential and privileged information, with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in § 23-63-531;

(B) Proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in § 23-63-531; and

(C) Any relevant information with the National Association of Insurance Commissioners or any third-party consultants designated by the commissioner;

(2) May receive documents, materials, or other own risk and solvency assessment information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in § 23-63-531, and from the National Association of Insurance Commissioners;

(3) Shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information;

(4)(A) Shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant to govern the sharing and use of information provided under this subchapter.

(B) The written agreement shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or a third-party consultant under this

subchapter, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers;

(ii) Provide that the recipient has agreed in writing to maintain the confidentiality and privileged status of the own risk and solvency assessment documents, materials, or other information, and has verified in writing the legal authority to maintain confidentiality;

(iii) Specify that ownership of information shared with the National Association of Insurance Commissioners or a third-party consultant under this subchapter remains with the commissioner and the National Association of Insurance Commissioners, or that a third-party consultant's use of the information is subject to the authority of the commissioner;

(iv) Prohibit the National Association of Insurance Commissioners or third-party consultant from storing the information shared under this subchapter in a permanent database after the underlying analysis is completed;

(v) Require prompt notice be given to an insurer whose confidential information is in the possession of the National Association of Insurance Commissioners or a third-party consultant under this subchapter that the confidential information is subject to a request or subpoena to the National Association of Insurance Commissioners or a third-party consultant for disclosure or production; and

(vi) Require the National Association of Insurance Commissioners or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action that the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant under this subchapter; and

(5) If an agreement involves a third-party consultant, shall provide that an insurer's written consent is required before sharing the requested information.

(f) The sharing of information and documents by the commissioner under this subchapter does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of this subchapter.

(g) A waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other own risk and solvency assessment information shall not occur as a result of disclosure of the own risk and solvency assessment information or documents to the commissioner under this section or as a result of sharing under this subchapter.

(h) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or third-party consultants under this subchapter:

(1) Shall be confidential by law and privileged; and

(2) Shall not be subject to:

- (A) The Freedom of Information Act of 1967, § 25-19-101 et seq.;
- (B) Subpoena; or
- (C) Discovery or admissible in evidence in any private civil action.

History. Acts 2015, No. 1223, § 31; 2017, No. 334, § 6. tice”, inserted “is” preceding “in the possession”, and inserted “that the confidential information”.

Amendments. The 2017 amendment, in (e)(4)(B)(v), deleted “to” following “no-

23-69-410. Sanctions.

(a) An insurer failing without just cause to timely file the own risk and solvency assessment summary report under this subchapter shall be required, after notice and hearing, to pay a penalty of one hundred dollars (\$100) for each day’s delay, to be recovered by the Insurance Commissioner, and the penalty so recovered shall be paid into the General Revenue Fund Account of the State Apportionment Fund.

(b) The maximum penalty under this section is ten thousand dollars (\$10,000).

(c) The commissioner may reduce the penalty under this section if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

History. Acts 2015, No. 1223, § 31.

SUBCHAPTER 5 — ARKANSAS INSURANCE BUSINESS TRANSFER ACT

SECTION.

- 23-69-501. Title.
- 23-69-502. Legislative findings — Purpose.
- 23-69-503. Definitions.
- 23-69-504. Venue.
- 23-69-505. Notice required.
- 23-69-506. Application — Insurance business transfer plan.
- 23-69-507. Opinion report — Review requirements.

SECTION.

- 23-69-508. Insurance business transfer plan — Review — Insurance Commissioner.
- 23-69-509. Insurance business transfer plan — Petition for court approval — Implementation order.
- 23-69-510. Oversight of operations.
- 23-69-511. Fees — Reimbursements.
- 23-69-512. Rules.

23-69-501. Title.

This subchapter shall be known and may be cited as the “Arkansas Insurance Business Transfer Act”.

History. Acts 2021, No. 1018, § 1.

23-69-502. Legislative findings — Purpose.

(a) The General Assembly finds that:

(1) There is not a basis or procedure for the transfer and novation of insurance policies from a transferring insurer to an assuming insurer

by way of an insurance business transfer without the affirmative consent of policyholders or reinsureds; and

(2) There is a need to provide a basis and procedures for the transfer and novation of insurance policies from a transferring insurer to an assuming insurer by way of an insurance business transfer without the affirmative consent of policyholders or reinsureds if the transfer and novation is conducted by a court order.

(b)(1) The purpose of this subchapter is to establish the requirements for notice and disclosure and standards and procedures for the approval of a transfer and novation by the Insurance Commissioner and the Pulaski County Circuit Court under an insurance business transfer plan.

(2) However, it is not the purpose of this subchapter to limit or restrict other means of effecting a transfer or novation.

History. Acts 2021, No. 1018, § 1.

23-69-503. Definitions.

As used in this subchapter:

(1) "Affiliate" means an affiliate as that term is defined in § 23-63-503;

(2) "Applicant" means a transferring insurer or reinsurer that submits an application under § 23-69-506;

(3)(A) "Assuming insurer" means an insurer domiciled in this state that assumes or seeks to assume policies from a transferring insurer under this subchapter.

(B) "Assuming insurer" may include a company established under § 23-63-1601 et seq.;

(4) "Implementation order" means an order issued by the Pulaski County Circuit Court under § 23-69-509;

(5) "Independent expert" means an impartial person who:

(A) Does not have a financial interest in either the transferring insurer or the assuming insurer;

(B) Has not been employed by or acted as an officer, director, consultant, or other independent contractor for either the transferring insurer or the assuming insurer within the past twelve (12) months;

(C) Has not been appointed by the Insurance Commissioner to assist in any capacity in any proceeding;

(D) Has not received any compensation in connection with an insurance business transfer under this subchapter other than a fee based on a fixed or hourly basis that is not contingent on the approval or consummation of the insurance business transfer; and

(E) Has proof of insurance coverage that is satisfactory to the commissioner;

(6)(A) "Insurance business transfer" means a transfer of insurance obligations or risks, or both, of existing or in-force contracts of

insurance or reinsurance from a transferring insurer to an assuming insurer.

(B) Once approved, the insurance business transfer shall effect a transfer and novation of the transferred contracts of insurance or reinsurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks, or both, under the contracts, are extinguished;

(7) "Insurance business transfer plan" means the plan submitted to the State Insurance Department to accomplish the transfer and novation under an insurance business transfer, including any associated transfer of assets and rights from or on behalf of the transferring insurer to the assuming insurer;

(8) "Insurer" means an insurance or surety company, including a reinsurance company, and includes a corporation, company, partnership, association, society, order, individual, or aggregation of individuals engaging in, proposing to engage in, or attempting to engage in any kind of insurance or surety business, including the exchanging of reciprocal or inter-insurance contracts between individuals, partnerships, and corporations;

(9) "Policy" means a policy, contract or certificate of insurance, or a contract of reinsurance under which the insurer agrees to assume an obligation or risk, or both, of the policyholder or to make payments on behalf of, or to, the policyholder or its beneficiaries, and includes property, casualty, life, health, and any other line of insurance the commissioner finds is suitable for an insurance business transfer;

(10) "Policyholder" means an insured or a reinsured under a policy that is part of a subject business;

(11) "Subject business" means the policy or policies that are the subject of the insurance business transfer plan;

(12) "Transfer and novation" means the transfer of insurance obligations or risks, or both, of existing or in-force policies from a transferring insurer to an assuming insurer, and is intended to effect a novation of the transferred policies with the result that:

(A) The assuming insurer becomes directly liable to the policyholders of the transferring insurer on the transferred policies; and

(B) The transferring insurer's insurance obligations or risks, or both, under the transferred policies are extinguished; and

(13) "Transferring insurer" means an insurer or reinsurer that transfers and novates or seeks to transfer and novate obligations or risks, or both, under one (1) or more policies to an assuming insurer under an insurance business transfer plan.

History. Acts 2021, No. 1018, § 1.

23-69-504. Venue.

(a) All court proceedings brought under this subchapter shall be filed in the Pulaski County Circuit Court.

(b) The court may issue any order, process, or judgment that is necessary or appropriate to carry out this subchapter.

(c) This subchapter does not preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules or to prevent an abuse of power.

History. Acts 2021, No. 1018, § 1.

23-69-505. Notice required.

(a) Except as otherwise ordered by the Pulaski County Circuit Court or the Insurance Commissioner, if notice is required to be given by the applicant under this subchapter, the applicant, within fifteen (15) days of the event triggering the requirement, shall cause transmittal of the notice:

(1) By first class mail, postage prepaid, to the chief insurance regulator in each jurisdiction in which the applicant holds or has ever held a certificate of authority, and in which policies that are part of the subject business were issued or where policyholders currently reside;

(2) By certified first class mail, postage prepaid, to the National Conference of Insurance Guaranty Funds, the National Organization of Life and Health Insurance Guaranty Associations, and all state insurance guaranty associations for the states in which the applicant holds or has ever held a certificate of authority, and in which policies that are part of the subject business were issued or where policyholders currently reside;

(3) To reinsurers of the applicant under the notice requirements of the reinsurance agreements applicable to the policies that are part of the subject business, or if an agreement does not require notice, by an internationally recognized delivery service;

(4)(A) By United States mail, first class postage prepaid, to all policyholders holding policies that are part of the subject business, at their last known address as indicated by the records of the applicant or to the address to which premium notices or other policy documents are sent.

(B) A notice of transfer shall be sent to the transferring insurer's agents or brokers of record on the subject business; and

(5) By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in such other publications that the commissioner requires.

(b) If notice is given under subsection (a) of this section, an order under this subchapter shall be conclusive with respect to all intended recipients of the notice, whether or not they receive actual notice.

(c) If the commissioner has been named receiver of the applicant, the commissioner shall provide the required notice under this subchapter.

History. Acts 2021, No. 1018, § 1.

23-69-506. Application — Insurance business transfer plan.

(a) An applicant shall file an insurance business transfer plan with the Insurance Commissioner for his or her review and approval.

(b) The insurance business transfer plan shall contain the following information or an explanation as to why the information is not included:

(1) The name, address, and telephone number of the transferring insurer and the assuming insurer and their respective direct and indirect controlling persons, if any;

(2) A summary of the insurance business transfer plan;

(3) The identification and description of the subject business;

(4) The most recent audited financial statements and annual and quarterly reports of the transferring insurer and assuming insurer filed with their domiciliary regulator;

(5) The most recent actuarial report and opinion that quantifies the liabilities associated with the subject business;

(6) The pro forma financial statements showing the projected balance sheet, results of operations, and cash flows of the assuming insurer for the three (3) years following the proposed transfer and novation;

(7) Officers' certificates of the transferring insurer and the assuming insurer attesting that each has obtained all required internal approvals and authorizations regarding the insurance business transfer plan and completed all necessary and appropriate actions as required;

(8) A proposal for implementation and administration of the insurance business transfer plan, including the form of notice to be provided under the insurance business transfer plan to any policyholder whose policy is part of the subject business;

(9) A full description of how the notice described in subdivision (b)(8) of this section shall be provided;

(10) A description of all reinsurance arrangements that would pass to the assuming insurer under the insurance business transfer plan;

(11) A description of any guarantees or additional reinsurance that will cover the subject business following the transfer and novation;

(12) A statement describing the assuming insurer's proposed investment policies and any contemplated third party claims management and administration arrangements;

(13) Evidence of approval or nonobjection of the transfer from the chief insurance regulator of the state of the transferring insurer's domicile;

(14)(A) An opinion report from an independent expert, selected by the commissioner from a list of at least two (2) nominees submitted jointly by the transferring insurer and the assuming insurer, to assist the commissioner and the Pulaski County Circuit Court in the review of the proposed transaction.

(B) If the commissioner, in his or her sole discretion, rejects the nominees described in subdivision (b)(14)(A) of this section, the commissioner may appoint an independent expert; and

(15) Any other information the commissioner deems necessary.

History. Acts 2021, No. 1018, § 1.

23-69-507. Opinion report — Review requirements.

(a) The opinion report required under § 23-69-506(b)(14) shall provide the following:

(1) A statement of the independent expert's professional qualifications, including a description of the experience that qualifies him or her as an expert suitable for the engagement;

(2) A statement indicating whether or not the independent expert has, or has had, direct or indirect interest in the transferring insurer or the assuming insurer or any affiliate of the transferring insurer or assuming insurer;

(3) A statement as to the scope of the opinion report;

(4) A summary of the terms of the insurance business transfer plan to the extent relevant to the opinion report;

(5) Documents, reports, and other material information the independent expert has considered in preparing the opinion report and if any information requested has not been provided;

(6) A statement indicating the extent to which the independent expert has relied on the information and judgment of others;

(7) The identities of the individuals on whom the independent expert has relied and a statement as to why, in the opinion of the independent expert, such reliance is reasonable;

(8) A statement of the independent expert's opinion of the likely effects of the insurance business transfer plan on policyholders and claimants, distinguishing between the following:

(A) Transferring policyholders and claimants;

(B) Policyholders and claimants of the transferring insurer whose policies will not be transferred; and

(C) Policyholders and claimants of the assuming insurer;

(9) For each opinion that the independent expert expresses in the opinion report, a statement of the facts and circumstances supporting the opinion; and

(10) A statement as to whether the security position of policyholders that are affected by the insurance business transfer are adversely materially affected by the insurance business transfer.

(b) The independent expert shall include in an opinion report:

(1) An analysis of the transferring insurer's actuarial review of reserves for the subject business to determine the reserve adequacy;

(2) An analysis of the financial condition of the transferring insurer and the assuming insurer and the effect the insurance business transfer will have on the financial condition of each insurer;

(3) A review of the plans or proposals the assuming insurer has with respect to the administration of the policies subject to the proposed insurance business transfer;

(4) An analysis of whether the proposed insurance business transfer will have an adverse material impact on the policyholders and claimants of the transferring insurer and the assuming insurer;

(5) An analysis of the assuming insurer's corporate governance structure to ensure that there is proper board and management oversight and expertise to manage the subject business; and

(6) Any other information that the Insurance Commissioner requests in order to review the insurance business transfer.

History. Acts 2021, No. 1018, § 1.

23-69-508. Insurance business transfer plan — Review — Insurance Commissioner.

(a)(1) The Insurance Commissioner shall have sixty (60) business days from the date of receipt of a completed application for an insurance business transfer plan filed under § 23-69-506 to review the insurance business transfer plan to determine if the applicant is authorized to submit it to the Pulaski County Circuit Court.

(2) The commissioner may extend the sixty-day review period for an additional thirty (30) business days.

(b) The commissioner shall authorize the submission of the insurance business transfer plan to the court unless he or she finds that the insurance business transfer would have an adverse material impact on the interests of policyholders or claimants that are part of the subject business.

(c) The commissioner shall not authorize the submission of the insurance business transfer plan to the court unless:

(1) The assuming insurer is licensed in each line of business in each state where the transferring insurer is licensed or the assuming insurer demonstrates an extraordinary circumstance preventing the assuming insurer from obtaining the license or licenses; and

(2) The commissioner determines that the lack of the license or licenses under subdivision (c)(1) of this section would not result in an adverse material impact on the interests of policyholders, contract holders, or reinsurers.

(d) If the commissioner determines that the insurance business transfer would have an adverse material impact on the interests of policyholders or claimants that are part of the subject business, the commissioner shall notify the applicant and specify any modifications, supplements, or amendments and any additional information or documentation with respect to the insurance business transfer plan that shall be provided to the commissioner before he or she allows the applicant to proceed with the court filing.

(e)(1) The applicant shall have thirty (30) days from the date the commissioner notifies him or her or it under subsection (d) of this section of the need to file an amended insurance business transfer plan providing the modifications, supplements, amendments, or additional information or documentation as requested by the commissioner.

(2) The applicant may request in writing an extension of time of thirty (30) days.

(3) If the applicant does not make an amended filing within the time period provided for in this subsection, including any extension of time granted by the commissioner under subdivision (e)(2) of this section, the insurance business transfer plan filing shall terminate, and a subsequent filing by the applicant shall be considered a new filing that shall require compliance with this subchapter as if the prior filing had never been made.

(f) The commissioner's review period shall recommence when the modification, supplement, amendment, or additional information or documentation is received.

(g) If the commissioner determines that the insurance business transfer plan may proceed with the court filing, the commissioner shall confirm that fact in writing to the applicant.

History. Acts 2021, No. 1018, § 1.

23-69-509. Insurance business transfer plan — Petition for court approval — Implementation order.

(a)(1) Within thirty (30) days after notice from the Insurance Commissioner that an applicant may proceed with filing the insurance business transfer plan with the Pulaski County Circuit Court, the applicant shall petition the court for approval of the insurance business transfer plan.

(2) Upon written request by the applicant, the commissioner may extend the period for filing a petition with the court for an additional thirty (30) days.

(b) An applicant shall inform the court of the reason for the applicant's petition to the court to approve the insurance business transfer plan on the basis that no adverse material impact to policyholders or claimants affected by the proposed insurance business transfer will result.

(c)(1) A petition shall be in the form of a verified petition to the court for implementation of the insurance business transfer plan through the court.

(2) The petition shall include the insurance business transfer plan and shall identify any documents and witnesses that the applicant intends to present at a hearing regarding the petition.

(d)(1) The commissioner shall be a party to the proceedings before the court concerning the petition and shall be served with copies of all filings according to the Arkansas Rules of Civil Procedure.

(2) The position of the commissioner in the proceeding shall not be limited by his or her initial review of the insurance business transfer plan.

(e)(1) Following the filing of the petition, an applicant shall file a motion for a scheduling order setting a hearing on the petition.

(2)(A) Within fifteen (15) days after receipt of the scheduling order, the applicant shall cause notice of the hearing to be provided according to § 23-69-505.

(B) Following the date of distribution of the notice, there shall be a comment period of sixty (60) days.

(f) The notice to policyholders shall provide:

(1) The date and time of the approval hearing;

(2) The name, address, and telephone number of the assuming insurer and transferring insurer;

(3) A statement that a policyholder may comment on or object to the transfer and novation;

(4) The procedures and deadline for submitting comments on or objections to the insurance business transfer plan;

(5) A summary of any effect that the transfer and novation will have on the policyholder's rights;

(6) A statement that the assuming insurer is authorized to assume the subject business and that court approval of the insurance business transfer plan shall extinguish all rights of policyholders under policies that are part of the subject business against the transferring insurer;

(7) A statement that a policyholder does not have the opportunity to opt out of or otherwise reject the transfer and novation;

(8) Contact information for the State Insurance Department for the policyholder to obtain further information; and

(9)(A) Information on how to access an electronic copy of the insurance business transfer plan.

(B) If a policyholder is unable to readily access an electronic copy of the insurance business transfer plan, the applicant shall provide a hard copy of the insurance business transfer plan to the policyholder by first class mail.

(g)(1) A person, including his, her, or its legal representative, who or that considers himself, herself, or itself to be adversely affected may present evidence or comments to the court at the approval hearing.

(2) However, the evidence or comments shall not confer standing on any person.

(3) A person participating in the approval hearing shall follow the process established by the court and shall be responsible for his, her, or its own costs and attorney's fees.

(h) After the comment period described in subdivision (e)(2)(B) of this section has ended, the insurance business transfer plan shall be presented by the applicant for approval by the court.

(i) At any time before the court issues an order approving the insurance business transfer plan, the applicant may withdraw the insurance business transfer plan without prejudice.

(j)(1) If the court finds that the implementation of the insurance business transfer plan would not have an adverse material impact on the interests of policyholders or claimants that are part of the subject business, the court shall enter an implementation order.

(2) The implementation order shall:

(A) Order implementation of the insurance business transfer plan;
(B) Order a transfer and novation with respect to all policyholders or reinsureds and their respective policies and reinsurance agreements under the subject business, including:

(i) The extinguishment of all rights of policyholders under policies that are part of the subject business against the transferring insurer;

(ii) Providing that the transferring insurer shall have no further rights, obligations, or liabilities with respect to such policies; and

(iii) Providing that the assuming insurer shall have all such rights, obligations, and liabilities as if the assuming insurer, instead of the transferring insurer, were the original insurer of such policies;

(C) Release the transferring insurer from all obligations or liabilities under policies that are part of the subject business;

(D)(i) Authorize and order the transfer of property or liabilities, including without limitation the ceded reinsurance of transferred policies and contracts on the subject business.

(ii) The subject business shall vest in and become a liability of the assuming insurer;

(E) Order that the applicant provide notice of the transfer and novation according to § 23-69-505; and

(F) Make any orders with respect to incidental, consequential, and supplementary matters as are necessary to assure the insurance business transfer plan is fully and effectively executed.

(k) If the court finds that the insurance business transfer plan should not be approved, the court by its order may:

(1) Deny the petition; or

(2) Provide the applicant leave to file an amended insurance business transfer plan and petition.

(l) This section does not affect the right of appeal for any party.

History. Acts 2021, No. 1018, § 1.

23-69-510. Oversight of operations.

Insurers subject to this subchapter consent to the jurisdiction of the Insurance Commissioner with regard to ongoing oversight of operations, management, and solvency relating to the transferred business, including the authority of the commissioner to conduct financial analysis and examinations.

History. Acts 2021, No. 1018, § 1.

23-69-511. Fees — Reimbursements.

(a) At the time of filing its application with the Insurance Commissioner for review and approval of an insurance business transfer plan, an applicant shall pay a nonrefundable fee to the State Insurance Department in the amount of ten thousand dollars (\$10,000).

(b) In the commissioner's discretion, the department may participate in the proceedings undertaken under this subchapter, and the applicant

shall reimburse the department for any compensation and benefits paid to the personnel of the department for time spent engaged in the proceedings, including without limitation examiners, actuaries, attorneys, managers, and paraprofessionals.

(c) The commissioner may retain independent attorneys, appraisers, actuaries, certified public accountants, or other professionals and specialists to assist department personnel in connection with the review required by this subchapter, and the cost shall be borne by the applicant.

(d) The applicant shall pay the expenses of the department and its authorized consultants incurred in fulfilling their obligations under this subchapter, including the actual expenses of the department or the expenses and compensation of any consultants retained by the department.

(e) Failure to pay any of the requisite fees or reimbursements within thirty (30) days of demand shall be grounds for the commissioner to request that the Pulaski County Circuit Court dismiss the petition for approval of the insurance business transfer plan before the filing of an implementation order by the court or, if after the filing of an implementation order, the commissioner may suspend or revoke the assuming insurer's certificate of authority to transact insurance business in this state.

History. Acts 2021, No. 1018, § 1.

23-69-512. Rules.

The Insurance Commissioner shall promulgate rules to implement this subchapter.

History. Acts 2021, No. 1018, § 1.

CHAPTER 71

STIPULATED PREMIUM INSURERS

SECTION.

23-71-103. Other provisions applicable.

23-71-103. Other provisions applicable.

In addition to the provisions contained in this chapter, other chapters and provisions of the Arkansas Insurance Code shall apply to stipulated premium plan insurers, to the extent so applicable, as follows:

- (1) Sections 23-60-101 — 23-60-108 and 23-60-110, scope of code;
- (2) Section 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq., the Insurance Commissioner;
- (3) Sections 23-63-102 — 23-63-104, 23-63-201 — 23-63-216, 23-63-301, 23-63-302, 23-63-303, and 23-63-304, authorization of insurers and general requirements, with the exception of the following sections:
 - (A) Section 23-63-205, capital funds required;

- (B) Section 23-63-207, special surplus requirement; and
- (C) Section 23-63-206, bond or deposit requirement;
- (4) Sections 23-60-102, 23-61-401, 23-61-402, 26-57-601 — 26-57-605, 26-57-607, 26-57-608, and 26-57-610, fees and taxes;
- (5) Provisions of § 23-63-601 et seq. as to assets and valuation of assets;
- (6) Sections 23-63-801 — 23-63-835, investments;
- (7) Section 23-64-101 et seq., agents;
- (8) Section 23-65-101 et seq., unauthorized insurers;
- (9) Sections 23-66-201 — 23-66-213, 23-66-301 — 23-66-306, 23-66-308 — 23-66-311, 23-66-313, 23-66-314, and 23-66-501 — 23-66-513, trade practices and frauds;
- (10) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, the insurance contract, except §§ 23-79-131 — 23-79-134, exemption of proceeds;
- (11) Sections 23-85-101 — 23-85-131, accident and health insurance policies;
- (12) The following provisions of §§ 23-69-101 — 23-69-103, 23-69-105 — 23-69-141, 23-69-143, and 23-69-149 — 23-69-156, organization and corporate procedures of domestic stock and mutual insurers:
 - (A) Section 23-69-103, inapplicability of general corporation statutes;
 - (B) Section 23-69-107, amendment of articles of incorporation;
 - (C) Section 23-69-111, corporate powers in general;
 - (D) Section 23-69-111, contributions authorized;
 - (E) Section 23-69-120, meetings of stockholders or members;
 - (F) Section 23-69-121, stockholders' voting rights;
 - (G) Section 23-69-122, proxies;
 - (H) Section 23-69-123, corrupt practices — penalty;
 - (I) Section 23-69-110, vacancies;
 - (J) Section 23-69-127, consideration for stock;
 - (K) Section 23-69-128, transfer of stock;
 - (L) Section 23-69-129, dividends to stockholders;
 - (M) Section 23-69-131, illegal dividends — penalty;
 - (N) Section 23-69-108, officers;
 - (O) Section 23-69-133, stockholders' liability;
 - (P) Section 23-69-109, prohibited pecuniary interest of officials;
 - (Q) Section 23-69-134, home office and records; penalty for unlawful removal of records;
 - (R) Section 23-69-135, vouchers for expenditures;
 - (S) Section 23-69-136, situs of personal property for taxation;
 - (T) Section 23-69-137, management and exclusive agency contracts;
 - (U) Section 23-69-139, assessment of stockholders or members;
 - (V) Sections 23-69-151 — 23-69-154, voluntary dissolution;
 - (W) Section 23-69-156, extinguishment of unused corporate charters;
- (13) Section 23-68-101 et seq., rehabilitation and liquidation;

(14) Section 23-62-205, reinsurance.

History. Acts 1959, No. 148, § 555; A.S.A. 1947, § 66-4416; Acts 1991, No. 804, § 2; 2001, No. 1566, § 13; 2001, No. 1603, § 30; 2001, No. 1604, §§ 70, 71; 2021, No. 367, § 17.

Amendments. The 2021 amendment, in (9), substituted "23-66-213" for "23-66-214" and inserted "and 23-66-501 — 23-66-513".

CHAPTER 72**MUTUAL ASSESSMENT LIFE AND DISABILITY INSURERS****SECTION.**

23-72-103. Other provisions applicable.

23-72-103. Other provisions applicable.

In addition to the provisions contained in this chapter, other chapters and provisions of the Arkansas Insurance Code shall apply to mutual assessment life and disability insurers, to the extent so applicable, as follows:

(1) Sections 23-60-101 — 23-60-108 and 23-60-110, scope of Arkansas Insurance Code;

(2) Section 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq., the Insurance Commissioner;

(3) Sections 23-63-102 — 23-63-104, 23-63-201 — 23-63-216, 23-63-301, and 23-63-302, authorization of insurers and general requirements, with the exception of the following sections:

(A) Section 23-63-205, capital funds required;

(B) Section 23-63-207, special surplus requirement; and

(C) Section 23-63-206, bond or deposit requirement;

(4) Applicable provisions of § 23-63-601 et seq., assets and liabilities;

(5) Applicable provisions of § 23-63-801 et seq., investments;

(6) Section 23-64-101 et seq., agents, brokers, and producers;

(7) Section 23-65-101 et seq., unauthorized insurers;

(8) Sections 23-66-201 — 23-66-213, 23-66-301 — 23-66-306, 23-66-308 — 23-66-311, 23-66-313, 23-66-314, and 23-66-501 — 23-66-513, trade practice and frauds;

(9) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, the insurance contract, except:

(A) Sections 23-79-131 — 23-79-134, exemption of proceeds;

(B) Section 23-79-204, venue; and

(C) Section 23-79-205, registered agents for service of process;

(10) The following provisions of §§ 23-69-101 — 23-69-103, 23-69-105 — 23-69-141, 23-69-143, and 23-69-149 — 23-69-156, organization and corporate procedures of domestic stock and mutual insurers:

(A) Section 23-69-103, inapplicability of general corporation statutes;

- (B) Section 23-69-107, amendment of articles of incorporation;
- (C) Section 23-69-111, corporate powers in general;
- (D) Section 23-69-111, contributions;
- (E) Section 23-69-120, meetings of stockholders or members;
- (F) Section 23-69-123, corrupt practices — penalty;
- (G) Section 23-69-110, removal of director — vacancies;
- (H) Section 23-69-108, officers;
- (I) Section 23-69-109, prohibited pecuniary interest of officials;
- (J) Section 23-69-134, home office and records and penalty for unlawful removal of records;
- (K) Section 23-69-135, voucher for expenditures;
- (L) Section 23-69-136, situs of personal property for taxation;
- (M) Section 23-69-137, management and exclusive agency contracts;
- (N) Sections 23-69-151 — 23-69-154, voluntary dissolution;
- (O) Section 23-69-155, mutual member's share of assets on liquidation; and
- (P) Section 23-69-156, extinguishment of unused corporate charters;
- (11) Applicable provisions of § 23-68-101 et seq., rehabilitation and liquidation; and
- (12) Section 23-62-205, reinsurance.

History. Acts 1959, No. 148, § 578; A.S.A. 1947, § 66-4523; Acts 1991, No. 804, § 3; 2001, No. 1566, § 15; 2021, No. 367, § 18.

Amendments. The 2021 amendment, in (8), substituted "23-66-213" for "23-66-214" and inserted "and 23-66-501 — 23-66-513".

CHAPTER 73

FARMERS' MUTUAL AID ASSOCIATIONS

SECTION.

23-73-104. Other provisions applicable.
23-73-113. Continuance of certificate of authority.

SECTION.

23-73-115. Management and exclusive agency contracts.
23-73-117. Conversion to mutual insurer.

23-73-104. Other provisions applicable.

In addition to the provisions of this chapter, farmers' mutual aid companies or associations shall also be subject to the following chapters and provisions of the Arkansas Insurance Code to the extent so applicable:

- (1) Sections 23-60-101 — 23-60-108 and 23-60-110, scope of Arkansas Insurance Code;
- (2) Section 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq., the Insurance Commissioner;
- (3) Section 23-65-101 et seq., unauthorized insurers;
- (4) Sections 23-66-201 — 23-66-213, 23-66-301 — 23-66-306, 23-66-308 — 23-66-311, 23-66-313, 23-66-314, and 23-66-501 — 23-66-513, trade practices and frauds;

(5) Section 23-79-208, suits against insurers — damages and attorney's fees, loss claims;

(6) Sections 23-68-101 — 23-68-113 and 23-68-115 — 23-68-132, rehabilitation and liquidation;

(7) Provisions of § 23-63-601 et seq., assets and reserves and valuation of assets;

(8) Sections 23-63-801 — 23-63-833 and 23-63-835, investments;

(9) Section 23-62-205, reinsurance;

(10) Section 23-69-134, maintenance of home office and records;

(11) Section 23-64-101 et seq., agents, brokers, solicitors, adjusters, and consultants. However, company or association officers and directors that also act as agents for their companies or associations shall not be required to license as agents, if the officers and directors do not receive commissions for policy sales;

(12) Sections 23-61-701 — 23-61-705, State Insurance Department Trust Fund fees;

(13) Section 23-79-109, filing and approval of forms;

(14) Sections 23-88-101, valued policy law and 23-88-102, paying costs of volunteer fire department services; and

(15) Section 23-63-201 et seq., authority to do business.

History. Acts 1959, No. 148, § 593; 1979, No. 942, § 18; A.S.A. 1947, § 66-4615; Acts 1991, No. 804, § 4; 1997, No. 774, § 1; 2001, No. 1566, § 17; 2019, No. 521, § 21; 2021, No. 367, § 19.

Amendments. The 2019 amendment added (15).

The 2021 amendment, in (4), substituted "23-66-213" for "23-66-214" and inserted "and 23-66-501 — 23-66-513".

23-73-113. Continuance of certificate of authority.

(a) For continuance of an original certificate of authority, a farmers' mutual aid company or association shall file with the Insurance Commissioner:

(1) A concise statement of its financial condition, management, and affairs on a form satisfactory to the commissioner;

(2) Other documents or stipulations as the commissioner may reasonably require to evidence compliance with the provisions of this chapter; and

(3) Pay any fees required by the Arkansas Insurance Code to be paid for filing the accompanying documents and for the certificate of authority if granted.

(b)(1) After September 1, 2005, the commissioner shall prepare and send to each qualified farmers' mutual aid association or company a substitute Arkansas certificate of authority evidencing full licensure from the original date when the association or company was issued a certificate of authority.

(2)(A) A certificate issued under subdivision (b)(1) of this section shall:

(i) Be and remain the property of the State of Arkansas;

(ii) Render any previous certificate of authority null and void as of the effective date of the new certificate;

(iii) Remain in force and effect until it expires or is suspended, revoked, or surrendered; and

(iv) Be continuous, subject to compliance with annual fee and reporting requirements.

(B) The association or company shall promptly deliver the certificate to the commissioner upon the certificate's expiration, suspension, revocation, or surrender.

(C)(i) If for any reason the association or company is not entitled to a continuation of the certificate of authority, the commissioner:

(a) May refuse to continue the certificate; and

(b) Shall give either written or electronic notice of the refusal to continue the certificate to the association or company.

(ii) The certificate of authority shall expire on the next May 1 following the notice provided in subdivision (b)(2)(C)(i)(b) of this section.

(c) After notice and a hearing, the commissioner may suspend or revoke a certificate of authority if the association or company:

(1) No longer meets the requirements for holding a certificate of authority or is impaired or insolvent;

(2) Is using methods or practices in the conduct of its business that unreasonably expose its members, policyholders, or the public to injury;

(3) Has refused to be examined or to produce its accounts, records, or files for examination when required by the commissioner, or if any of its officers, directors, or key personnel have refused to give information with respect to the association's or company's affairs when required by the commissioner;

(4) Has failed to pay a final judgment against it; or

(5) Has violated or failed to comply with any applicable provision of the Arkansas Code or any lawful order or rule of the commissioner.

History. Acts 1959, No. 148, § 590; **Amendments.** The 2019 amendment A.S.A. 1947, § 66-4612; Acts 1997, No. substituted "rule" for "regulation" in 774, § 1; 2005, No. 2004, § 3; 2019, No. (c)(5). 315, § 2393[2693].

23-73-115. Management and exclusive agency contracts.

(a)(1) No farmers' mutual aid company or association shall make any contract whereby any person is granted or is to enjoy in fact the management of the company or association or to have the controlling or preemptive right to produce substantially all insurance business for the company or association, unless the contract is filed with and approved by the Insurance Commissioner.

(2) The contract shall be deemed approved, unless disapproved by the commissioner within thirty (30) days after date of filing, subject to such reasonable extension of time as the commissioner may require by notice given within the thirty (30) days.

(3) Any disapproval shall be delivered to the company or association in writing, stating the grounds therefor.

(b) The commissioner shall disapprove any contract if the commissioner finds that it:

- (1) Subjects the company or association to excessive charges;
- (2) Is to extend for an unreasonable length of time;
- (3) Does not contain fair and adequate standards of performance;
- (4) Grants the management of the association, to the substantial exclusion of its board of directors, to any person, corporation, partnership, joint venture, limited partnership, or limited liability company;
- (5) Requires the association to guarantee the manager's obligation or performance to anyone other than the association;
- (6) Allows the manager to assign its rights under the agreement to a third party without the consent of the board of directors and the commissioner; or
- (7) Contains other inequitable provisions which impair the proper interests of the company or association.

(c) The commissioner, in his or her discretion, may require submission of a contract for review at any time if he or she believes a review would be in the best interest of policyholders of the company or association.

(d)(1) No association shall indemnify or insure its manager's obligations to any other person or entity, unless by operation of law.

(2) To the extent allowed by law, any indemnification by the association shall be limited to the extent of any insurance or reinsurance coverages applicable to the loss indemnified or insured.

(e) The association shall disclose to the commissioner the name of any member of its board of directors that is also an officer, stockholder, agent, partner, limited partner, limited liability company member, joint venturer, or employee of the manager.

(f) The acts of the manager may be examined as if it were the association.

(g) The commissioner may adopt reasonable rules for the implementation and administration of the provisions of this section.

History. Acts 1959, No. 148, § 593.1, as added by Acts 1983, No. 522, § 34; A.S.A. 1947, § 66-4616; Acts 1997, No. 774, § 1; 2001, No. 1811, § 1; 2019, No. 315, § 2694.

Amendments. The 2019 amendment deleted "and regulations" following "rules" in (g).

23-73-117. Conversion to mutual insurer.

(a) A farmers' mutual aid association as provided for by this chapter may be converted to a mutual insurer as defined in § 23-69-102 under any plan or procedure which may be approved by the order of the Insurance Commissioner after a hearing thereon.

(b) The commissioner shall approve a plan or procedure if he or she finds that:

- (1) The plan would not be contrary to law and would not be contrary to the interest of insureds or the public; and

(2) The plan has been approved by a vote of not less than two-thirds ($\frac{2}{3}$) of the members present or represented by proxy at the meeting, or such greater majority as may be otherwise provided in the association's bylaws. Voting shall be conducted by written ballot which shall be signed by the member, on a ballot form approved by the commissioner prior to voting.

(c) Upon conversion, the association shall possess and thereafter maintain unimpaired surplus as regards policyholders of not less than seven hundred fifty thousand dollars (\$750,000).

(d) Upon conversion to a mutual insurer as provided for herein, the association shall be subject to and comply with all laws and rules applicable to mutual insurers.

(e) Any association so converted shall be authorized to write only those lines for which it was authorized to write as a farmers' mutual aid association. However, the converted company may seek to have its certificate of authority amended to write additional lines.

(f) The association shall have a period of time which shall be specified in the commissioner's order to complete the conversion.

(g) Any association converted to a mutual insurer under the provisions of this section shall be designated as a "mutual insurer", and that designation shall appear immediately following its name on all policies, financial statements, and other documents where its name appears.

History. Acts 1985, No. 489, § 1; A.S.A. 1947, § 66-4617; Acts 1997, No. 774, § 1; 2019, No. 315, § 2695.

Amendments. The 2019 amendment substituted "rules" for "regulations" in (d).



